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IN THE

Supreme Court of the United States

No. 70-40, 1971 Term

MARY DOE, *et al.*,

Appellants,

—v.—

ARTHUR K. BOLTON, Attorney General of the State of Georgia, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA

MOTION FOR LEAVE TO FILE A BRIEF AS *AMICI CURIAE* FOR THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, NEW YORK ACADEMY OF MEDICINE, MEDICAL SCHOOL DEANS AND PROFESSORS, AND CERTAIN INDIVIDUAL PHYSICIANS

Pursuant to Rule 42(3) of this Court, the organizations and physicians named on the cover and initial pages of this Motion, respectfully ask leave to file the annexed brief as *Amici Curiae* in the above-styled case.

Counsel for appellant have not responded to the request for leave to file a brief. Counsel for appellee asked *Amici* to seek the leave of this Court.

Interest of *Amici Curiae*

Amici are organizations and individuals from the medical profession generally, as well as particular specialties.

Amicus American College of Obstetricians and Gynecologists was founded in 1951 and has 13,400 Fellows and Junior Fellows. ACOG was organized in part to "establish and maintain the highest possible standards for obstetric and gynecologic education in medical schools and hospitals,

obstetric and gynecologic practice and research" and to "maintain the dignity and efficiency of obstetric and gynecologic practice in its relationship to public welfare." The ACOG "Policy on Abortion" recognizes that "abortion may be performed at a patient's request, or upon a physician's recommendation." (For complete text of policy statement, *see* Appendix A.)

Amicus American Medical Women's Association, which was organized over 56 years ago, is composed of some 2,000 women physicians and women medical students throughout the United States and territories. AMWA has supported liberalization of abortion laws "for those who, for family planning or health reasons, wish it, and that this be done with the approval of their physicians."

Amicus American Psychiatric Association is a scientific and educational medical organization, composed of 18,783 qualified doctors of medicine who specialize as psychiatrists in the diagnosis, care and treatment of mental diseases and defects of the mind. It is the second largest medical specialty organization in the United States. Abortions are a prime interest to psychiatrists because pregnancy, child-bearing, birth and abortion can have material effects upon the mental processes of patients requiring psychiatric diagnosis, evaluation and care. The Board of Trustees of the APA on Dec. 12-13, 1969, upon the recommendation of the Committee on Psychiatry and Law, approved the following:

"Position Statement on Abortion"

"A decision to perform an abortion should be regarded as strictly a medical decision and a medical responsibility. It should be removed entirely from the jurisdiction of criminal law. Criminal penalties should be reserved for persons who perform abortions without medical license or qualifications to do so. A medical decision to perform an abortion is based on the careful and informed judgments of the physician and the patient. Among other factors to be considered in arriving at the decision is the motivation of the patient.

> Often psychiatric consultation can help clarify motivational problems and thereby contribute to the patient's welfare."

Composed of 3,118 Fellows, *Amicus* the New York Academy of Medicine was incorporated, by special act of the Legislature of the State of New York in 1851, for the advancement of science and medicine:

> "The New York Academy of Medicine recommends repeal of those sections of the criminal code referable to the performance of abortion by qualified physicians and further supports the legal changes that would place abortion under the general provisions of the medical practices act of all the various states."

The individual *Amici* also include over 170 medical school deans, departmental chairmen, and professors of both obstetrics and gynecology and other branches of medicine.

Amici have a vital interest in overturning the jurisdictional holding of the lower court. The panel found no "case or controversy" posed by the sub-class of physician plaintiffs. *Doe* v. *Bolton,* 319 F. Supp. 1048, 1052-54 (N.D. Ga. 1970) (per curiam); J.S., at 4-a to 9-a. Although the district court upheld the "standing" of the physician class, the judges denied that physicians who "are not free to perform or counsel the obtaining of abortions" may contest the law short of inviting criminal prosecution. *Id.*

This determination runs completely contrary to decisions by this Court, *e.g., Investment Co. Institute* v. *Camp,* 401 U.S. 617, 620 (1971); *LSCRRC* v. *Wadmond,* 401 U.S. 154, 158-59 (1971); *Epperson* v. *Arkansas,* 393 U.S. 97, 101-02 (1968); *Abbott Laboratories* v. *Gardner,* 387 U.S. 136, 151-53 (1967). It also asks the near impossible of physicians and their patients. Either a pregnant woman must file an action and await lengthy judicial deliberations which risk her very life and health (fifteen weeks intervened between the April 16, 1970, filing date and the July 31 decision in this case). Or, a physician must invite criminal prosecution, where none is necessary to reveal the continuing im-

pact of the statute's restrictions. Only two physicians in Anglo-American history have had sufficient courage to choose the latter route. *See Rex* v. *Bourne* [1939] 1 K.B. 687; *Hodgson* v. *Randall*, 314 F. Supp. 32 (D. Minn. 1970), *aff'd mem.*, 402 U.S. —— (May 17, 1971).

Amici have a second important interest in the merits. The Georgia law regulating the medical procedure of abortion is patterned after analogous Model Penal Code provisions.[1] Similar laws are currently in force in twelve states.[2] *Amici* include or represent physicians from each of these additional jurisdictions. A decision on this appeal will have the effect of settling, one way or another, objections to those other eleven statutes. For this reason, *Amici* have a legitimate claim to be heard.

Equally important to the *Amici* is the need to present medical data to the Court concerning the implementation of this type of legislation. On a cumulative as well as state-by-state basis, data have gradually become available from public health authorities. These reveal discriminatory variations in access to medical abortions, from county-to-county, hospital-to-hospital, and state to state. All purport to be operating under similar statutory language.

To the extent that these data have bearing upon the constitutional questions before this Court, *Amici* have prepared illustrative tables and charts. These appear in Appendix B to the brief annexed hereto.

Amici Curiae, as physicians, also have data and argument in support of the contention that state law cannot rationally differentiate the medical procedure of abortion from all other procedures, by limiting the former to general community hospitals accredited by the Joint Commission on Accreditation of Hospitals [JCAH]. The aforementioned tables and charts show the paucity of such fully

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[1] *See* MODEL PENAL CODE §230.3, at 189 (Proposed Official Draft, 1962); *Id.*, §207.11, at 144 (Tent. Draft No. 9, 1959), both of which follow almost verbatim from the fifteen year old 1955 draft.

[2] The twelve states are: Arkansas, California, Colorado, Delaware, Kansas, Maryland, New Mexico, North Carolina, Oregon, South Carolina, Virginia, and Georgia.

accredited hospitals in the affected states, such as Georgia, Arkansas, and another eight states with substantially the same requirement. This lack of available facilities is accentuated by the tendency for many accredited hospital directorates to permit their physicians to perform few or no medical abortions.

In some states, however, the laws permit specialized abortion facilities. In others, data from abortion experience suggests that the limitation of this medical procedure to fully accredited general community hospitals goes far beyond legitimate public health demands. *Amici* have assembled the most relevant and recent scientific findings. These are discussed in the annexed brief.

In two respects the brief for *Amici Curiae* will supplement the brief for appellants in a manner useful to the Court. First, *Amici* will concentrate arguments primarily on the interference of the statute with physicians, patients, and the physician-patient relationship.

Second, *Amici* will present these arguments from a national perspective, by showing how the Georgia-type law compares with laws in other states, both in terminology and implementation at the statewide, county, and hospital levels.

For the most part, the data materials are no more technical than the far more extensive records filed in antitrust, patent, and food and drug litigation. *Amici* have prepared the annexed brief and appendix to ensure that the Court will not be without what Judge Learned Hand denominated as "the aid of unpartisan and authoritative scientific assistance in the administration of justice" in this case. *See Parke-Davis & Co.* v. *H. K. Mulford Co.*, 189 Fed. 95, 115 (C.C.S.D.N.Y. 1911) (L. Hand, J., referring to the need for technical assistance in interpreting the patent on "adrenalin.").

For the reasons set forth, the Court should grant the Motion of *Amici* and receive the annexed brief.

Respectfully submitted,

Roy Lucas,
Attorney for Movant Amici Curiae.

IN THE

Supreme Court of the United States

No. 70-40, 1971 Term

MARY DOE, *et al.*,

Appellants,

—v.—

ARTHUR K. BOLTON, Attorney General of the State of Georgia, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA

BRIEF AS *AMICI CURIAE* FOR THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, NEW YORK ACADEMY OF MEDICINE, MEDICAL SCHOOL DEANS AND PROFESSORS, AND CERTAIN INDIVIDUAL PHYSICIANS

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Other Statutes and Rules:

Abortion Services, N.Y.C. HEALTH CODE tit. III, Art. 42, 98 CITY RECORD 6313-6315 (Oct. 23, 1970) 89

Family Planning Services and Population Research Act of 1970, Pub. L. No. 91-572 (Dec. 24, 1970) 18

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Cases:

Abbott Laboratories v. Gardner, 387 U.S. 136 (1967) ..30, 36
Alabama State Teachers Ass'n v. Lowndes County Bd. of Education, 289 F. Supp. 300 (M.D. Ala. 1968) 66
American Commuters Ass'n v. Levitt, 279 F. Supp. 40 (S.D.N.Y. 1967) 95
Application of Georgetown College, Inc., 331 F.2d 1010 (D.C. Cir.) (en banc), *cert. denied*, 377 U.S. 978 (1964) 44
Avery v. Midland County, 390 U.S. 474 (1967) 65

Baggett v. Bullitt, 377 U.S. 360 (1964) 29
Baker v. Carr, 369 U.S. 186 (1962) 23
Baldwin v. Hale, 68 U.S. (1 Wall.) 223 (1864) 78
Barrows v. Jackson, 346 U.S. 249 (1953) 24
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Birnbaum v. Trussell, 371 F.2d 672 (2d Cir. 1966) 22
Blake v. McClung, 172 U.S. 239 (1898) 93
Boddie v. Connecticut, 401 U.S. 371 (1971) ..... *passim*
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Brooks v. Beto, 366 F.2d 1 (5th Cir. 1966) 62
Brotherhood of Railway Trainmen v. Virginia, 377 U.S. 1 (1964) 40

California v. Belous, 71 Cal.2d 954, 458 P.2d 194, 80 Cal. Rptr. 354 (Sept. 5, 1969), *cert. denied*, 397 U.S. 915 (1970) ..... *passim*
Canale v. Stevenson, —— Tenn. ——, 458 S.W.2d 797 (1970) 66
Clayton v. North Carolina State Bd. of Elections, 317 F. Supp. 915 (E.D.N.C. 1970) 65
Corfield v. Coryell, 6 Fed. Cas. 546 (C.C.E.D. Pa., 1832) (No. 3,230) 92
Corkey v. Edwards, 322 F. Supp. 1248 (W.D.N.C.), *appeal docketed*, 40 U.S.L.W. 3048 (U.S. July 17, 1971) (No. 71-92, 1971 Term) 29, 90
Crossen v. Breckenridge, —— F.2d ——, No. 20852 (6th Cir. June 23, 1971) 24

Dent v. West Virginia, 129 U.S. 114 (1889) 27, 38, 39, 51
Doe v. Bolton, 319 F. Supp. 1048 (N.D. Ga. 1970) (per curiam), *juris. postponed*, 402 U.S. —— (May 3, 1971) (No. 70-40, 1971 Term) ..... *passim*
Doe v. Dunbar, 320 F. Supp. 1297 (D. Colo. 1970) 29
Doe v. Randall, 314 F. Supp. 32 (1970) 26
Doe v. Scott, 321 F. Supp. 1385 (N.D. Ill.) *appeal docketed sub nom.* Hanrahan v. Doe, 39 U.S.L.W. 3438 (U.S. Mar. 29, 1971) (No. 70-105, 1971 Term) 29

Eisenstadt v. Baird, 429 F.2d 1398 (1st Cir. 1970), *prob. juris. noted*, 401 U.S. 934 (1971) (No. 70-17, 1971 Term) 73

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Elfbrandt v. Russell, 384 U.S. 11 (1966) 89
Epperson v. Arkansas, 393 U.S. 97 (1968) 29

Goldberg v. Kelly, 397 U.S. 254 (1970) 79
Golden v. Zwickler, 394 U.S. 103 (1969) 28
Graham v. Richardson, 402 U.S. —— (June 14, 1971) 45, 46, 95
Gray v. Sanders, 372 U.S. 363 (1963) 61
Greene v. McElroy, 360 U.S. 474 (1959) 22, 79-80
Griffin v. County School Board, 377 U.S. 218 (1964) 64, 65, 67
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Hall v. Beals, 396 U.S. 45 (1969) 30
Harper v. Virginia Board of Elections, 383 U.S. 663 (1966) 61
Hawkins v. Town of Shaw, Mississippi, 437 F.2d 1286 (5th Cir. 1971) 62, 65
Hodgson v. Randall, 314 F. Supp. 32 (D. Minn. 1970) *aff'd mem.*, 402 U.S. —— (May 17, 1971) 29-30

Iowa Nat'l Bank v. Stewart, 214 Iowa 1229, 232 N.W. 445 (1930) 34

Jacobson v. Massachusetts, 197 U.S. 11 (1904) 43, 48

Kennan v. Nichol, —— F. Supp. ——, 71-C-118 (W.D. Wis. Apr. 27, May 5, 6, 1971) 35
King v. Smith, 392 U.S. 309 (1968) 73

Lane v. Wilson, 307 U.S. 268 (1939) 66, 67
Long v. Robinson, 316 F. Supp. 22 (D.Md. 1970), *aff'd*, 436 F.2d 1116 (4th Cir. 1971) 65

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Loving v. Commonwealth, 388 U.S. 1 (1967) 43
LSCRRC v. Wadmond, 401 U.S. 154 (1971) 29

McCann v. Babbitz, 310 F. Supp. 293 (E.D. Wis. Mar. 5, 1970) (per curiam) *appeal dismissed,* 400 U.S. 1 (1970) (per curiam) 13, 29
McCann v. Babbitz, 320 F. Supp. 219 (E.D. Wis. 1970) (per curiam), *vacated for consideration,* 402 U.S. 903 (1971) 35
McCready v. Virginia, 94 U.S. 391 (1877) 95
Morey v. Doud, 354 U.S. 457 (1957) 46, 69, 84
Mullaney v. Anderson, 342 U.S. 415 (1952) 95

NAACP v. Alabama, 357 U.S. 449 (1958) 40
NAACP v. Button, 371 U.S. 415 (1963) 40
Norwalk CORE v. Norwalk Redevelopment Agency, 395 F.2d 920 (2d Cir. 1968) 66

Olmstead v. United States, 277 U.S. 438 (1928) 44
Orr v. Thorp, 308 F. Supp. 1369 (S.D. Fla. 1969) 66

Paul v. Virginia, 75 U.S. (8 Wall.) 168 (1869) 92-93
People v. Barksdale, —— Cal. App. 3d ——, —— Cal. Rptr. ——, 1 Crim. 9526 (Calif. Dist. Ct. App. July 22, 1971) 90
Perez v. Ledesma, 401 U.S. 82 (1971) 36
Pierce v. Society of Sisters, 268 U.S. 510 (1925) 24, 32, 33, 44
Poe v. Ullman, 367 U.S. 497 (1961) 30, 31, 32, 33

Rex v. Bourne [1938] 3 All Eng. Rep. 615 [1939] 1 K.B. 687 29
Reynolds v. Sims, 377 U.S. 533 (1964) 61, 65, 67

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Richards v. Townsend, 303 F. Supp. 793 (N.D. Calif. 1969) 66
Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970) (per curiam), *juris. postponed,* 402 U.S. —— (May 3, 1971) (No. 70-18, 1971 Term) ..... *passim*
Ruffalo, *In Re,* 390 U.S. 544 (1968) 79

Sams v. Ohio Valley General Hospital Ass'n, 413 F.2d 826 (4th Cir. 1969) 65
Schware v. Board of Bar Examiners, 353 U.S. 232 (1957) 38
Shapiro v. Thompson, 394 U.S. 618 (1969) 46, 95
Shuttlesworth v. City of Birmingham, 394 U.S. 147 (1969) 85
Skinner v. Oklahoma, 316 U.S. 535 (1942) 43-44, 47-48
Slochower v. Board of Higher Education, 350 U.S. 551 (1956) 22
Smith v. Texas, 233 U.S. 630 (1914) 38
Sniadach v. Family Finance Corp., 395 U.S. 337 (1969) 79
Southern Pacific Terminal Co. v. ICC, 219 U.S. 498 30
Stanley v. Georgia, 394 U.S. 557 (1969) 44
State v. Coleman, 46 N.J. 16, 214 A.2d 393 (1965) 34
State v. Fowler, 193 N.C. 290, 136 S.E. 709 (1927) 66
State v. Swegori, 318 Mo. 998, 2 S.W.2d 747 (1924) 66
Steinberg v. Brown, 321 F. Supp. 741 (N.D. Ohio 1970) 20, 29
Swain v. Alabama, 380 U.S. 202 (1965) 61

Terrace v. Thompson, 263 U.S. 197 (1923) 33
Terry v. Ohio, 392 U.S. 1 (1968) 43
Tileston v. Ullman, 318 U.S. 44 (1943) (per curiam) 22

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Toomer v. Witsell, 334 U.S. 385 (1948) 93, 94, 95
Truax v. Raich, 239 U.S. 33 (1915) 24, 32

Union Pac. Ry. v. Botsford, 141 U.S. 250 (1891) 43, 48
United Mine Workers v. Illinois State Bar, 389 U.S. 217 (1967) 40
United States v. Freund, 290 Fed. 411 (D. Mont. 1923) 39
United States v. O'Brien, 391 U.S. 367 (1968) 41
United States v. Vuitch, 305 F. Supp. 1035 (D.D.C. Nov. 10, 1969), *modified and reversed*, 402 U.S. 62 (1971) ..... *passim*
United Transportation Union v. State Bar of Michigan, 401 U.S. 576 (1971) 40
United States *ex rel.* Dr. Jesse Williams, II v. Zelker, —— F.2d ——, No. 35381 (2d Cir. July 2, 1971) (Tom C. Clark, J.) 24
United States *ex rel. Lawrence* v. *Woods*, 432 F.2d 1072 (7th Cir. 1970), *cert. denied*, 402 U.S. —— (May 17, 1971) 34

Valle v. Stengel, 176 F.2d 697 (3d Cir. 1949) 94

Ward v. Maryland, 79 U.S. 418 (1870) 93
West Virginia Board of Education v. Barnette, 319 U.S. 624 (1943) 33
Willner v. Committee on Character and Fitness, 373 U.S. 96 (1963) 22

Yick Wo v. Hopkins, 118 U.S. 356 (1886) 48
Young v. United States, 315 U.S. 257 (1942) 27
Younger v. Harris, 401 U.S. 37 (1971) 25

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MEDICAL LITERATURE AND COMMENTARY:

Aarons, *Therapeutic Abortion and the Psychiatrist,* 124 AM. J. PSYCHIATRY 745 (1967) 75
Abortion, Proceedings of the American Medical Ass'n House of Delegates 47 (June, 1970) 52
AM. J. OBST. & GYN. 694 (1969) 58
Anderson & Speroff, *Prostaglandins,* 171 SCIENCE 502 (1971) 88
Appendectomy Profile, 1968, 7 PAS REPORTER No. 16, at 1-4 (Dec. 22, 1969) 11
AREY, L., DEVELOPMENTAL ANATOMY (7th ed. 1965) 9

Baird, D., *The Obstetrician and Society,* 60 AM. J. PUBLIC HEALTH 628 (1970) 59
BASIC DOCUMENTS OF THE WORLD HEALTH ORGANIZATION 1 (Geneva 1969 ed.) 42
Bourne, *et al., Surveillance of Legal Abortions in the United States, 1970* (Proceedings, 9th Annual Meeting, American Ass'n of Planned Parenthood Physicians, Kansas City, Mo., April 5-6, 1971) 31
Bumpass & Westoff, *The "Perfect Contraceptive" Population,* 169 SCIENCE 1177 (1970) 14, 18, 20

CALDERONE, M. (ed.), ABORTION IN THE UNITED STATES (1958) 14, 56
Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (Report released by the Health Services Administration, City of New York) 15, 31, 61
Cholecystectomy Mortality, 8 PAS REPORTER No. 8, at 1 (Apr. 20, 1970) 11
CLAPESATTLE, H., THE DOCTORS MAYO (1941) 42, 90

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Crowley & Laidlaw, *Psychiatric Opinion Regarding Abortion: Preliminary Report of a Survey*, 124 Am. J. Psychiatry 145 (1967) 56

Curran, *The Right to Health in National and International Law*, 284 New Eng. J. of Medicine 1258 (1971) 42

Davis, L. E., Fellowship of Surgeons: A History of the American College of Surgeons (1960) 81

Droegemueller, Taylor & Drose, *The First Year of Experience in Colorado with the New Abortion Law*, 103

Dryfoos, *et al.*, *Eighteen Months Later: Family Planning Services in the United States, 1969*, 3 Family Planning Perspectives No. 2, at 29 (Apr. 1971) 19

Fisher, *Criminal Abortion*, in Abortion in America 3-6 (H. Rosen ed. 1967) 14

Forssman & Thuwe, *One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused*, 42 Acta Psychiatric Scandinavia 71-88 (1966) reprinted in Abortion and the Unwanted Child 123 (C. Reiterman ed. 1971) 20

Gebhard, P., *et al.*, Pregnancy, Birth and Abortion (1958) 14

Goldsmith & Margolis, *Aspiration Abortion Without Cervical Dilation*, 110 Am. J. Obstetrics & Gynecology 580 (1971) 87

Group for the Advancement of Psychiatry, the Right to Abortion: A Psychiatric View (Comm. on Law & Psychiatry, 1970) 57

Hall, *Abortion in American Hospitals*, 57 Am. J. Pub. Health 1933 (1967) 56

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HELLMAN, L., & PRITCHARD, J., WILLIAMS OBSTETRICS (14th ed. 1971) 7, 9, 55

Huntingford, *Mortality and Morbidity of Abortion,* THE LANCET 1012 (May 15, 1971) 86

Hook, *Refused Abortion,* 37 ACTA PSYCHIAT 203 (1961) 56

Israel & Mazer, *Safety and Advantage of Office Curettage,* 36 AM. J. OBSTETRICS & GYNECOLOGY 445 (1938) 88

Margolis & Overstreet, *Legal Abortion Without Hospitalization,* 36 OBSTETRICS & GYNECOLOGY 479 (1970) 86

Need For Subsidized Family Planning Services: United States, Each State and County, 1968 Table I, p. 92 (Office of Economic Opportunity, 1968) 19

NOVAK, E., *et al.,* TEXTBOOK OF GYNECOLOGY (8th ed. 1970) 16

Overstreet, *Abortion and Obstetrics,* in II ABORTION IN A CHANGING WORLD 74 (R. Hall ed. 1970) 55

PAS Hospitals, 8 PAS REPORTER No. 1, at 1 (Jan. 12, 1970) 10, 11

PATTEN, B., HUMAN EMBRYOLOGY (3d ed. 1968) 9

PEEL, J., & POTTS, M., CONTRACEPTIVE PRACTICE (1969) 17

Penfield, *Abortion Under Paracervical Block,* 71 N. Y. STATE J. OF MEDICINE 1185 (1971) 87

Pike, *Therapeutic Abortion and Mental Health,* 111 CALIF. MEDICINE, 318 (1969) 56, 58

Potts, *Postconceptive Control of Fertility,* 8 INTERNATIONAL J. OF GYNECOLOGY & OBSTETRICS 957 (1970) .. 8, 12

Regine, *A Study of Pregnancy Wastage,* 13 MILBANK MEM. FUND QUART. No. 4, at 347-65 (1935) 14

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Rochat, *et al., An Epidemiological Analysis of Abortion in Georgia,* 61 AM. J. PUBLIC HEALTH 543 (1971) 16, 60, 64, 71

Russell & Jackson, *Therapeutic Abortions in California,* 105 AM. J. OBST. & GYN. 757 (1969) 57

Ryan, *Humane Abortion Laws and the Health Needs of Society,* 17 W. RES. L. REV. 424 (1965) 10, 58, 73

SCHWARZ, R. H., SEPTIC ABORTION (1968) 15, 57

Speroff & Ramwell, Prostaglandins in Reproductive Physiology, 107 AM. J. OBSTETRICS & GYNECOLOGY 1111 (1970) 88

T & A Profile, 8 PAS REPORTER No. 5 (Mar. 9, 1970) 11

TAUSSIG, F., ABORTION: SPONTANEOUS AND INDUCED (1936) 14

Thompson, Cowen & Berris, *Therapeutic Abortion: A Two-Year Experience in One Hospital,* 213 J. AM. MEDICAL ASS'N. 991 (1970) 59

Tietze, *Abortion Laws and Abortion Practices in Europe,* in V ADVANCES IN PLANNED PARENTHOOD 194 (1969) (Proceedings of the Seventh Annual Meeting of the American Ass'n of Planned Parenthood Physicians) 12, 71

Tietze, *United States: Therapeutic Abortions, 1963-1968,* 59 STUDIES IN FAMILY PLANNING 5 (1970) ..... *passim*

Tietze, *et al., Teaching of Fertility Regulation in Medical Schools,* 196 J. AMERICAN MEDICAL ASS'N 20 (1966) 19

Walter, *Psychologic and Emotional Consequences of Elective Abortion,* 36 OBSTETRICS & GYNECOLOGY 482 (1970) 50

PAGE

White, *Induced Abortions: A Survey of their Psychiatric Implications, Complications, and Indications,* 24 TEX. REPS. OF BIOLOGY & MEDICINE 531 (1966) 57, 58

Willson, *Abortion—A Medical Responsibility?,* 30 OBSTETRICS & GYNECOLOGY 294 (1967) 51

Willson, *et al.,* OBSTETRICS AND GYNECOLOGY 178 (4th ed. 1971) 77

LEGAL COMMENTARY:

BICKEL, A., THE LEAST DANGEROUS BRANCH (1962) 32, 34

Clark, *Religion, Morality, and Abortion: A Constitutional Appraisal,* 2 LOYOLA UNIV. (L.A.) L. REV. 1 (1969) .....*passim*

Comment, 50 CALIF. L. REV. 137 (1962) 32

Declaratory Relief in the Criminal Law, Note, 80 HARV. L. REV. 1940 (1967) 32

Louisell, *Abortion, the Practice of Medicine and the Due Process of Law,* 16 U.C.L.A.L. REV. 233 (1969) 58

Louisell & Noonan, *Constitutional Balance,* in THE MORALITY OF ABORTION 249 (Noonan ed. 1970) 57

Moyers, *Abortion Laws: A Study in Social Change,* 7 SAN DIEGO L. REV. 237 (1970) 59

Overstreet, in *Symposium—Pregnancy Termination: The Impact of New Laws,* 6 J. REPRODUCTIVE MEDICINE 274 (June 1971) 77

Packer & Gampell, *Therapeutic Abortion: A Problem in Law and Medicine,* 11 STAN. L. REV. 417 (1959) ... 57

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Roemer, *Abortion Law Reform and Repeal: Legislative and Judicial Developments,* 61 AM. J. PUBLIC HEALTH 500 (1971) 14

Schwartz, *Moral Offenses and the Model Penal Code,* 63 COLUM. L. REV. 669 (1963) 37

Sedler, *Standing to Assert Constitutional Jus Tertii,* 71 YALE L.J. 599 (1962) 24

Smith, *et al., Report to the Legislature: State of Hawaii—Hawaii's Abortion Law* 15 (Apr. 20, 1971) 80

WILLIAMS, G., THE SANCTITY OF LIFE AND THE CRIMINAL LAW (1966) 25

OTHER AUTHORITIES:

Abortion Regulations Adopted by the Washington State Board of Health (Dec. 10, 1970) 89

Accreditation Manual for Hospitals 1 (JCAH 1970) .. 81

Bulletin No. 42, JCAH (Aug. 1966) 84

Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (Report by Health Services Administration, City of New York) 91

Constitution of the World Health Organization, in BASIC DOCUMENTS OF THE WORLD HEALTH ORGANIZATION 1 (Geneva 1969 ed.) 50

Hospitals, 44 J. AM. HOSPITAL ASS'N 1 (1970) (Guide Issue) 91

Jain & Sinding, *North Carolina Abortion Law 1967* (Carolina Population Center 1968) 59

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MODEL PENAL CODE §207.11, Comments (Tent. Draft No. 9, 1959) 52, 81

Model Penal Code §230.3(2) (Proposed Official Draft, 1962) 14

Policy on Abortion, American College of Obstetricians and Gynecologists (Aug. 1970) 52

Recommended Standards for Abortion Services (APHA 1970) 89

Statement by John I. Brewer, M.D., Commissioner JCAH (July 9, 1971) 82, 83

UNIFORM ABORTION ACT (2d Tent. Draft 1970) 52, 80

1 U.S. Bureau of the Census, *Census of Population* ch. a (1960) 62

U.S. Bureau of the Census: *Statistical Abstracts of the United States: 1970*, Table 69, at 55 (91st ed.) .. 10, 20

IN THE

Supreme Court of the United States

No. 70-40, 1971 Term

MARY DOE, *et al.*,

Appellants,

—v.—

ARTHUR K. BOLTON, Attorney General of the State of Georgia, *et al.*,

Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA

BRIEF FOR THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, NEW YORK ACADEMY OF MEDICINE, MEDICAL SCHOOL DEANS AND PROFESSORS, AND CERTAIN INDIVIDUAL PHYSICIANS AS *AMICI CURIAE*

Interest of *Amici Curiae*

The professional and personal interests of the *Amici Curiae* in the subject matter of this case are described in the Motion for leave to file this brief, *supra.*

Questions Presented

I. Whether the district court should have granted both declaratory and injunctive relief to the class of physician plaintiffs, to prevent continuing drastic and irreparable

injury caused by the statute in question, which sharply curtails access to the medical procedure of induced abortion.

II. Whether the classifications in Georgia Criminal Code §§26-1201, -1202(a)(1)-(3), -1202(b)(1)-(9), -1202(c), and -1202(e), which differentiate the medical procedure of induced abortion from all other forms of therapeutic and elective health care, by:

[A] confining the procedure to the limited number of hospitals both accredited by the Joint Commission on Accreditation of Hospitals [JCAH] and licensed as hospitals by the Georgia State Board of Health; and

[B] requiring that the patient's chosen physician obtain the approval of (1) two additional examining physicians, and (2) a hospital committee of three or more physicians before performing a medical abortion; and

[C] limiting the medical justifications for the procedure to instances certified by all of the above physicians wherein: (1) continuation of pregnancy would "endanger the life" of the woman, or "seriously and permanently injure her health," or (2) "[t]he fetus would very likely be born with a grave, permanent, and irremedial mental or physical defect," or (3) "[t]he pregnancy resulted from forcible or statutory rape;" and further

[D] restricting access to the medical procedure of induced abortion to the single class of patients who are "bona fide legal resident[s] of the State of Georgia,"

violate the Equal Protection and Due Process clauses of the Fourteenth Amendment by unjustifiably abridging the fundamental personal rights to administer and seek medical care.

Statute Involved

GEORGIA CRIMINAL CODE §§26-1201, through -1203, at 85-89 (1969) provides:

26-1201. *Criminal abortion.*—Except as otherwise provided in section 26-1202, a person commits criminal abortion when he administers any medicine, drug or other substance whatever to any woman or when he uses any instrument or other means whatever upon any woman with intent to produce a miscarriage or abortion.

26-1202. *Exception.*—(a) Section 26-1201 shall not apply to an abortion performed by a physician duly licensed to practice medicine and surgery pursuant to Chapter 84-9 or 84-12 of the Code of Georgia of 1933, as amended, based upon his best clinical judgment that an abortion is necessary because:

(1) A continuation of the pregnancy would endanger the life of the pregnant woman or would seriously and permanently injure her health; or

(2) The fetus would very likely be born with a grave, permanent, and irremedial mental or physical defect; or

(3) The pregnancy resulted from forcible or statutory rape.

(b) No abortion is authorized or shall be performed under this section unless each of the following conditions is met:

(1) The pregnant woman requesting the abortion certifies in writing under oath and subject to the penal-

ties of false swearing to the physician who proposes to perform the abortion that she is a bona fide legal resident of the State of Georgia.

(2) The physician certifies that he believes the woman is a bona fide resident of this State and that he has no information which should lead him to believe otherwise.

(3) Such physician's judgment is reduced to writing and concurred in by at least two other physicians duly licensed to practice medicine and surgery pursuant to Chapter 84-9 of the Code of Georgia of 1933, as amended, who certify in writing that based upon their separate personal medical examinations of the pregnant woman, the abortion is, in their judgment, necessary because of one or more of the reasons enumerated above.

(4) Such abortion is performed in a hospital licensed by the State Board of Health and accredited by the Joint Commission on Accreditation of Hospitals.

(5) The performance of the abortion has been approved in advance by a committee of the medical staff of the hospital in which the operation is to be performed. This committee must be one established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals, and its approval must be by a majority vote of a membership of not less than three members of the hospital's staff; the physician proposing to perform the operation may not be counted as a member of the committee for this purpose.

(6) If the proposed abortion is considered necessary because the woman has been raped, the woman makes a written statement under oath, and subject to the penalties of false swearing, of the date, time and place of the rape and the name of the rapist, if known. There must be attached to this statement a certified copy of any report of the rape made by any law enforcement officer or agency and a statement by the solicitor general of the judicial circuit where the rape occurred or allegedly occurred that, according to his best information, there is probable cause to believe that the rape did occur.

(7) Such written opinions, statements, certificates, and concurrences are maintained in the permanent files of such hospital and are available at all reasonable times to the solicitor general of the judicial circuit in which the hospital is located.

(8) A copy of such written opinions, statements, certificates, and concurrences is filed with the Director of the State Department of Public Health within 10 days after such operation is performed.

(9) All written opinions, statements, certificates, and concurrences filed and maintained pursuant to paragraphs (7) and (8) of this subsection shall be confidential records and shall not be made available for public inspection at any time.

(c) Any solicitor general of the judicial circuit in which an abortion is to be performed under this section, or any person who would be a relative of the child within the second degree of consanguinity, may petition the superior court of the county in which the abortion is to be performed for a declaratory judgment

whether the performance of such abortion would violate any constitutional or other legal rights of the fetus. Such solicitor general may also petition such court for the purpose of taking issue with compliance with the requirements of this section. The physician who proposes to perform the abortion and the pregnant woman shall be respondents. The petition shall be heard expeditiously and if the court adjudges that such abortion would violate the constitutional or other legal rights of the fetus, the court shall so declare and shall restrain the physician from performing the abortion.

(d) If an abortion is performed in compliance with this section, the death of the fetus shall not give rise to any claim for wrongful death.

(e) Nothing in this section shall require a hospital to admit any patient under the provisions hereof for the purpose of performing an abortion, nor shall any hospital be required to appoint a committee such as contemplated under subsection (b) (5). A physician, or any other person who is a member of or associated with the staff of a hospital, or any employee of a hospital in which an abortion has been authorized, who shall state in writing an objection to such abortion on moral or religious grounds shall not be required to participate in the medical procedures which will result in the abortion, and the refusal of any such person to participate therein shall not form the basis of any claim for damages on account of such refusal or for any disciplinary or recriminatory action against such person.

26-1203. *Punishment.*—A person convicted of criminal abortion shall be punished by imprisonment for not less than one nor more than 10 years.

Statement of the Case

The specific facts which gave rise to this action and appeal are fully set out in appellants' brief. *Amici* will accordingly not repeat those matters, but will concentrate instead upon the broader national impact of the Court's decision in this case, and background data which may aid the Court in its deliberations.

I. *Medical Aspects of Abortion*

The standard text on obstetrics and gynecology, coauthored by the dean of American gynecology, now Deputy Assistant Secretary for Population Affairs, HEW, Louis M. Hellman, M.D., defines abortion, both *spontaneous* and *induced,* as follows:

> "Abortion is the termination of a pregnancy at any time before the fetus has attained a stage of viability. Interpretations of the word 'viability' have varied between fetal weights of 400 g (about 20 weeks of gestation) and 1,000 g (about 28 weeks of gestation) . . . . Although our smallest surviving infant weighed 540 g at birth, survival even at 700 or 800 g is unusual." L. HELLMAN & J. PRITCHARD, WILLIAMS OBSTETRICS 493 (14th ed. 1971).

The procedure of *induced* abortion differs from *spontaneous* not in the result, nor in the underlying reason for the abortion but primarily in its being conscious and volitional. For example, a patient infected with rubella (German measles) may abort spontaneously, because her *body* rejects a badly damaged embryo. Another similarly situated patient may seek an *induced* abortion as part of a reasoned *mental* judgment in order to reject a damaged embryo in favor of a subsequent normal pregnancy. From

this perspective, "spontaneous abortion can be regarded as an important biologic mechanism which has evolved in viviparous animals to deal with the numerous embryologic errors arising during development." Potts, *Postconceptive Control of Fertility,* 8 INTERNATIONAL J. OF GYNECOLOGY & OBSTETRICS 957 (1970).

Spontaneous abortions cannot be brought about, under current technology, solely by the will of the patient. Yet, the bio-chemical systems of patients play an increasing role in what had previously been regarded as an accidental phenomenon. One recent study of spontaneously aborted embryos showed that 38% "had a chromosomal abnormality." Carr, *Chromosome Studies in Selected Spontaneous Abortions,* 37 OBSTETRICS & GYNECOLOGY 750 (1971). Not only do fetal defects frequently cause spontaneous abortion, but numerous other causes beyond the patient's control, and often working in her favor, appear to be involved. In fact, "[w]hen pregnancy is defined as beginning at fertilization or implantation, then the rate of spontaneous wastage is even higher and may approach 50%." Potts, *supra.*

No law requires that a patient seek or a physician provide treatment to prevent *spontaneous* abortion. Neither nature nor the law values an embryo which the patient's bio-chemical system rejects. In such cases the needs of the patient, and the treatment provided by the physician are committed by law in every state to the discretion of the physician and patient, and accepted medical practice. No hospital committees interfere with this relationship; no government programs seek to promote confinement and treatment in cases of threatened spontaneous abortion.

Indeed, spontaneous abortions before the fourth week of pregnancy are "perceived by the patient as delayed men-

struation or may not be recognized at all." L. HELLMAN & J. PRITCHARD, WILLIAMS OBSTETRICS 496 (14th ed. 1971). This is perhaps the case because in early pregnancy, when the overwhelming number of all abortions take place, embryonic development has scarcely begun. "The 4 weeks old embryo measures 5 mm. [1/5 in.]. . . ." Shettles, *Fertilization and Early Development From the Inner Cell Mass,* in SCIENTIFIC FOUNDATIONS OF OBSTETRICS AND GYNECOLOGY 154 (E. E. Philipp, *et al.,* eds. 1970). As noted in standard embryology texts,

> "during these early stages, the development of all mammals is fundamentally the same. The specific characteristics of any form emerge but slowly, and relatively late. . . . The illustrations of sections of 5-mm human embryos are quite applicable, for example, to similarly located sections of 5-mm pig embryos. The basic plan of early body structure is amazingly similar." B. PATTEN, HUMAN EMBRYOLOGY 5 (3d ed. 1968).

The 5-mm embryo, for example, still has "a conspicuous *tail* . . ." L. AREY, DEVELOPMENTAL ANATOMY 98 (7th ed. 1965) (italics in original).

Neither the medical profession nor state health authorities treat spontaneous or induced abortions prior to 20 weeks of development as events which in any way are comparable to the loss of human life. As one prominent physician recently stated:

> "To the medical profession operating within its present framework, the conceptus, prior to twenty weeks of age, does not have the same legal status as one after that time. Should there be an untimely birth before twenty weeks, the act is considered an abortion, not a delivery, and is not listed on the

> mother's parity record. A birth or death certificate is not required and the body is handled as a pathological specimen without requiring legal interment." Ryan, *Humane Abortion Laws and the Health Needs of Society,* 17 W. Res. L. Rev. 424, 427 (1965).

Induced abortion, in medical practice, is a relatively minor surgical procedure, insofar as risks to the patient's physical or mental well-being are concerned. This exceptional safety consideration was noted by Dr. John McKelvey, former head of obstetrics and gynecology at the University of Minnesota:

> "Under ideal circumstances, abortions can be done with very little vital risk. The procedures which are open to the poor on the contrary can be very risky not only to the life of the individual but to her future health." McKelvey, *The Abortion Problem,* 50 Minn. Med. 119, 124 (1967).

The degree of safety can be readily seen by comparing patient mortality rates for induced abortion with those of childbirth and other typical medical procedures.

The maternal mortality rate in the United States for 1967 averaged 28.0 deaths per 100,000 live births. For nonwhites the rate was almost three times as high, 69.5 deaths per 100,000 live births.[1] The comparable mortality rates for various surgical procedures in the United States, per 100,000 operations, have been as follows:[2] Appendectomy[3]

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[1] U.S. Bureau of the Census: *Statistical Abstracts of the United States: 1970,* Table 69, at 55 (91st ed.).

[2] The data are derived from surveys by the Commission on Professional and Hospital Activities, in Ann Arbor, Michigan, which are published in the Professional Activities Survey (PAS) Re-

—400 per 100,000; Cholecystectomy[4] (gall bladder operation)—1,600 per 100,000; Tonsillectomy/adenoidectomy[5]—5.2 per 100,000.

In the years 1963 to 1968, therapeutic abortions were unavailable in the United States on any large scale. Most patients had to show serious physical or mental disease to obtain the procedure. Of the 9,722 therapeutic abortions in the 1963-68 survey by the Commission on Professional and Hospital Activities only a single death "unequivocally resulted from the operation."[6] This death represents the equivalent of a mortality rate of 10.3 per 100,000 therapeutic abortions. Even this figure is misleadingly high in that the abortion was induced by an abdominal operation (hysterotomy) which poses substantial hazards of its own. Nonetheless, a 10.3 rate is 2.7 times safer than childbirth, 38.8 times safer than appendectomy, and 155 times safer than cholecystectomy, all other factors being equal.

A more correct estimation of the surgical risks from induced abortion can be made by examining the induced abortion mortality rates from other jurisdictions, in which abortion is available as an elective procedure in cases of contraceptive failure.

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porter. Over 1,200 hospitals provide the Commission with data for more than 10 million patients per year. *See PAS Hospitals*, 8 PAS Reporter No. 1, at 1 (Jan. 12, 1970).

[3] *Appendectomy Profile, 1968*, 7 PAS Reporter No. 16, at 1-4 (Dec. 22, 1969).

[4] *Cholecystectomy Mortality*, 8 PAS Reporter No. 8, at 1 (Apr. 20, 1970).

[5] *T & A Profile*, 8 PAS Reporter No. 5 (Mar. 9, 1970).

[6] Tietze, *United States: Therapeutic Abortions, 1963-1968*, 59 Studies in Family Planning 5, 7 (1970).

In England and Wales, which only recently reformed their 1803 abortion law, the 1968-1969 data showed a total of 15 deaths from 54,000 legal abortions, a rate of 28.0 per 100,000.[7] This included, however, "the many surgeons within the N.H.S. [National Health Service] who perform a few abortions each [and] have had a higher death rate (36/100,000) than the few surgeons who do many abortions in private practice (14.2/100,000)."[8]

Again, the British data do not begin to demonstrate the safety of elective abortion in a sample wherein the patients are healthy, the medical practitioners skilled, and the procedures undertaken in very early pregnancy. This circumstance, moreover, does not exist even in northern Europe "where rates of about 40 per 100,000 have been reported in recent years."[9] There, higher mortality rates resulted in large part from "the fact that a substantial proportion of legal abortions is performed after the third month of gestation."[10] Only in eastern Europe, where "almost all legal abortions are performed in the first trimester of pregnancy with the majority in the second month,"[11] have mortality rates fallen to as few as 1.2 per 100,000 operations (Hungary: 1964-67, 9 deaths, 739,000 legal abortions).

The extent to which elective induced abortion for healthy women is enormously safer than childbirth and various

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[7] Potts, *Postconceptive Control of Fertility*, 8 INTERNATIONAL J. OF GYNECOLOGY & OBSTETRICS 957, 967 (1970).

[8] *Id.*

[9] Tietze, *Abortion Laws and Abortion Practices in Europe*, in V ADVANCES IN PLANNED PARENTHOOD 194, 208 (1969) (Proceedings of the Seventh Annual Meeting of the American Ass'n of Planned Parenthood Physicians).

[10] *Id.*

[11] *Id.*

other medical procedures can be seen by tabulating the figures given above:

Medical Procedure or Event	Mortality (per 100,000 procedures)
Elective induced abortion (Hungary: 1964-67)	1.2
Tonsillectomy (U. S.: PAS 1969)	5.2
Therapeutic induced abortion (U. S.: 1963-68)	10.3
Childbirth (U. S.: 1967)	28.0
Appendectomy (U. S.: PAS 1968)	400
Cholecystectomy (U. S.: PAS 1968)	1,600

From these figures, it should be abundantly clear that a state must carry a heavy burden of persuasion to classify induced abortion apart from other medical procedures in terms of any public health or safety considerations.

In sum, the medical procedure of induced abortion, which is severely restricted by the statute involved in this case, is potentially 23.3 (28/1.2) times as safe as the process of going through ordinary childbirth. Numerous lower state and federal courts have reviewed or taken judicial notice of the facts set out in holding that no legitimate public health rationale could justify restrictive abortion legislation. *See, e.g., California* v. *Belous,* 71 Cal.2d 954, 965, 458 P.2d 194, 200, 80 Cal. Rptr. 354, 360 (1969), *cert. denied,* 397 U.S. 915 (1970); *McCann* v. *Babbitz,* 310 F. Supp. 293, 301 (E.D. Wis.) (per curiam), *appeal dismissed,* 400 U.S. 1 (1970) (per curiam).

II. *Incidence of Medically Induced Abortion*

In the United States on the whole, induced abortion under medical auspices was relatively restricted until 1967, when the first of twelve states, Colorado, enacted the American

Law Institute abortion law proposal in the Model Penal Code.[12] Georgia followed in 1968.

Only 5,000 therapeutic abortions were estimated to have been done in United States medical facilities in 1963,[13] as contrasted with 200,000 to 1,000,000 unwanted pregnancies thought to be terminated annually outside of the clinical setting.[14] These are over and above the "nearly 20 percent of all recent births [which] were unwanted," according to the "1965 National Fertility Study (NFS) . . . ." Bumpass & Westoff, *The "Perfect Contraceptive" Population*, 169 SCIENCE 1177, 1180 (1970).

Since 1967, the incidence of abortions in medical facilities has risen substantially, but only in the few states which have removed virtually all restrictions that previously differentiated abortion from other forms of medical treatment.

In New York City alone, for example, nearly 165,000 abortions were performed between July 1, 1970, and May

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[12] MODEL PENAL CODE §230.3(2) (Proposed Official Draft, 1962). The Twelve states are Arkansas, California, Colorado, Delaware, Georgia, Kansas, Maryland, New Mexico, North Carolina, Oregon, South Carolina, and Virginia. *See generally* Roemer, *Abortion Law Reform and Repeal: Legislative and Judicial Developments*, 61 AM. J. PUBLIC HEALTH 500 (1971).

[13] Tietze, *supra* note 6.

[14] Secret induced abortions are inherently incapable of quantification. Nonetheless, one can be certain that the number is very high. For estimates, see Fisher, *Criminal Abortion*, in ABORTION IN AMERICA 3-6 (H. Rosen ed. 1967); M. CALDERONE (ed.), ABORTION IN THE UNITED STATES 180 (1958); P. GEBHARD *et al.*, PREGNANCY, BIRTH AND ABORTION 136-37 (1958); F. TAUSSIG, ABORTION: SPONTANEOUS AND INDUCED 25 (1936); Regine, *A Study of Pregnancy Wastage*, 13 MILBANK MEM. FUND QUART. No. 4, at 347-55 (1935).

31, 1971.[15] Nearly 40,500 of these women were not residents of New York State![16]

III. *Incidence and Sequelae of Nonmedical Abortion*

The problem of abortions induced by nonmedical personnel, in circumstances conducive to infection, psychic trauma, and not infrequently death, remains with the medical profession in most other states, however.

> "[S]eptic abortion has become a leading cause of maternal deaths. In Philadelphia over 50 percent of the maternal deaths result from complications of abortion, and this fact apparently holds true in other areas of the country: Stevenson reports 57 percent in Michigan; Hellman, 33 percent at the Kings County Hospital in Brooklyn; and Fox, 28 percent in California." R. SCHWARZ, SEPTIC ABORTION 7 (1968).

The booklength treatment by Dr. Schwarz of the University of Pennsylvania School of Medicine could never have been written but for the legal restrictions on abortion. The chapters describe in detail the medical techniques of treating patients who are refused abortion by physicians and then resort to incompetent, nonmedical practitioners. These patients often return for treatment of complications that can be traced back to statutes such as that in question in this case.

Georgia remains among the states with an exceptionally low number of medical abortions. Despite an ostensibly more generous statute, Georgia has a serious continuing public health problem in illegal abortions induced by un-

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[15] Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (Report released by the Health Services Administration, City of New York).

[16] *Id.*

trained practitioners in dangerous settings. For the 1968-1970 period Georgia was *last* in number of abortions per 1,000 births among the twelve states with Model Penal Code-type therapeutic abortion acts. In Georgia the ratio was 4.0, by contrast with California where a similar law resulted in 194.2 abortions per 1,000 births for 1970 (*See* APPENDIX B, *infra,* Table I-2, at B-5, 6, for data on all twelve states). Only "5 percent of the practicing physicians in Georgia reported performing abortions in 14 percent of Georgia's counties during 1968 and 1969." Rochat, *et al., An Epidemiological Analysis of Abortion in Georgia,* 61 AM. J. PUBLIC HEALTH 543, 547 (1971).

IV. *Abortion and Contraception*

A. *Contraceptive Failure:*

Significant contraceptive failure rates, and widespread lack of information about contraception, are two of the many factors which must be understood in assessing the impact of abortion laws on families and individuals in Georgia, and the United States.

A wealth of medical evidence shows that the factual basis for this position is sound.

The most effective contraceptive known, "the pill" or oral contraceptive, has in practice produced side effects "disagreeable enough to cause a 20 to 40 per cent drop-out rate" among those patients who were informed of and chose to use the method in the first place. E. NOVAK, *et al.,* TEXTBOOK OF GYNECOLOGY 647 (8th ed. 1970). The vast proportion of the population not receiving family planning services never reach that option, of course. Other methods are less effective in practice than the 99% effective oral contraceptive. *Id.* These range from the intrauterine devices, which pose problems of their own and vary in

effectiveness, to abstention and rhythm, which are not seriously regarded by the medical profession in this century.[17]

The following chart illustrates the contraceptive failure problem:

Failure Rates of Contraceptive Methods

Method	*Pregnancy rates for 100 woman-years of use*[18]	
	High	*Low*
No contraceptive	80	80
Aerosol foam	—	29
Foam tablets	43	12
Suppositories	42	4
Jelly or cream	38	4
Douche	41	21
Diaphragm and jelly	35	4
Sponge and foam powder	35	28
Condom	28	7
Coitus interruptus	38	10
Rhythm	38	0
Lactation	26	24
Steroid contraception (the "pill")	2.7	0
Abortion	0	0
Intrauterine contraception (averages)		
Lippes loop (large)		
0-12 months	2.4	
12-24 months	1.4	

SOURCE: After Berelson et al., *Family Planning and Population Programs,* University of Chicago Press, 1966.

[17] For discussion of contraceptive-techniques, effectiveness, and the full range of complex factors involved, *see generally* J. PEEL & M. POTTS, CONTRACEPTIVE PRACTICE (1969).

[18] The factor of patient *use*, or non-use is always relevant. Highly motivated, sophisticated users might have no failure with a contraceptive foam, for example.

The number 80 in the first line indicates that among 100 women utilizing no contraception for one year, 80 will become pregnant.

B. *Lack of Access to Contraception:*

All too frequently it is presumed that people have access to and are able to use highly effective contraceptives, and are themselves at fault in cases of unwanted or unplanned pregnancy. This assumption could not be further from medical reality. Contraception is not widely available in the United States. In fact, Congress passed the *Family Planning Services and Population Research Act of 1970*, Pub. L. No. 91-572 (Dec. 24, 1970), with an overall appropriation exceeding $380 million "to assist in making comprehensive voluntary family planning services readily available to all persons. . . ." National studies on the magnitude of unwanted births, such as data from HEW's 1965 National Fertility Study, for example, showed:

> "[In] the period 1960 to 1965 there were 4.7 million births that would have been prevented by 'perfect contraception.' These births represent one fifth of all births during the period. Approximately two million of these births occurred among the poor and the near-poor and half of these among Negro poor and near-poor." [19]

The most recent studies identify as a principal problem the absence of adequate information and services for people with a need to know about contraception, and when

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[19] Bumpass & Westoff, *The "Perfect Contraceptive" Population*, 169 SCIENCE 1177, 1179 (1970).

that fails, medically induced abortion. As late as the close of 1969,

> "some 4.3 million women in need of subsidized family planning services were not receiving them insofar as could be determined from reports of organized programs; no programs at all could be identified in 1,636 counties—53 percent of all counties—containing one-fourth of the unmet need. Services continue to be concentrated in relatively few populous counties. . . ." [20]

The basic 1968 study covered each State by county. In Georgia a total of 179,932 medically indigent women in need of family planning information were shown to be unserved. This amounted to 88% of such women.[21] These individuals can hardly be thought to be able to protect their marital and personal privacy through contraception, when that is altogether unavailable to them.

This deficiency is not confined to patients. Only a few short years ago, a review of texts used in medical schools revealed that "[t]wo thirds of the texts (25 texts) contained either no mention of contraception or only isolated reference to it, with no complete discussion." Tietze, *et al., Teaching of Fertility Regulation in Medical Schools,* 196 J. AMERICAN MEDICAL ASS'N 20, 23 (1966).

Patients have limited access to contraceptive methods and information. Physicians have limited willingness to

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[20] Dryfoos, *et al., Eighteen Months Later: Family Planning Services in the United States, 1969,* 3 FAMILY PLANNING PERSPECTIVES No. 2, at 29 (Apr. 1971).

[21] *Need for Subsidized Family Planning Services: United States, Each State and County, 1968,* Table I, p. 50, cols. 10 & 11 (OEO, 1968).

prescribe contraception. As if this were not enough, contraceptive devices, techniques, and use are far from effective as a means whereby a family can determine how many children they will have and no more.

While a narrow concern is occasionally voiced that "'those who dance must pay the piper,'"[22] such an approach to judicial reasoning obscures the medical and legal issues. In the first place, studies of unwanted fertility, such as Bumpass & Westoff, *supra,* were of samples of *married* couples. This study did not evaluate the fact that 339,200 illegitimate births occurred in 1968, which at that time were 9.7% of all births.[23]

In or out of wedlock, unwanted pregnancy can have damaging consequences, not only for the married couple, or unmarried woman, but more so for the society which must face and deal with anti-social behavior, delinquency, and crime brought about to some degree by unwantedness. A detailed study of 120 children who were born after their mothers' applications for therapeutic abortions had been turned down in Sweden casts light upon the social consequences of restrictive abortion laws.[24] Among the "unwanted" group, by their twenty-first birthday, 28.3% had received psychiatric care, 18.3% had been registered with child welfare boards for delinquency, 8.3% were on the penal register, and 14.2% had received public assistance. The authors concluded:

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[22] Steinberg v. Brown, 321 F. Supp. 741, 747 (N.D. Ohio 1970).

[23] U.S. Bureau of the Census, *Statistical Abstract of the United States: 1970,* Table 58, at 50 (91st ed.).

[24] Forssman & Thuwe, *One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused,* 42 Acta Psychiatric Scandinavia 71-88 (1966), reprinted in Abortion and the Unwanted Child 12 (C. Reiterman ed. 1971).

"[T]he very fact a woman applies for legal abortion means that the prospective child runs a risk of having to surmount greater social and mental handicaps than its peers, even when the grounds for the application are so slight that it is refused." [25]

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Amici have presented the above analysis and data to introduce the medical and social context of this case. The data and conclusions which follow therefrom, are not intended to suggest that this Court, or any judicial body, ought to weigh policy matters to determine questions of constitutional law. Only when it is claimed that a statute interferes with a litigant's fundamental personal rights, is it incumbent upon the Court to inquire into the case. Such an inquiry must ask the nature of the rights asserted, whether such rights are implicit or express in constitutional doctrine, and whether a legislative body might justifiably abridge the rights asserted. The very nature of the rights in this case necessitates an understanding of contraception, abortion, and associated phenomena. The response to possible legislative justifications similarly requires an examination of medical and social facts. In the threshold treatment above, and in the arguments which follow, *Amici* will concentrate on particularly relevant medical data thought to be necessary to the Court's ultimate determination of law.

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[25] *Id.* at 143.

ARGUMENT

JURISDICTION

I.

The District Court had jurisdiction to grant declaratory and injunctive relief to the class of physicians.

A. Physicians have standing to assert their own fundamental personal rights, and those of the class of their patients who seek medical advice and treatment, because enforcement of the statute in question is almost solely against physicians, the physicians' interests are inextricably related to those of their patients, and the rights of patients cannot be adequately protected unless considered along with those of physicians.

1. *Standing of Physicians*

The sub-class of physicians alleged throughout that the statute in question directly curtailed their own interests in providing adequate medical advice and treatment for patients. These interests are aspects of "liberty," "property," and association directly protected by the First and Fourteenth Amendments. There can no longer be doubt that the opportunity to pursue one's profession is encompassed within the concepts of "liberty" and "property." This has been the teaching of decisions involving members of and aspirants to the bar, *Willner* v. *Committee on Character and Fitness,* 373 U.S. 96, 102-03 (1963); teachers, *Slochower* v. *Board of Higher Educ.,* 350 U.S. 551 (1956); scientists, *Greene* v. *McElroy,* 360 U.S. 474, 492 (1959); and physicians as well, *Birnbaum* v. *Trussell,* 371 F.2d 672 (2d Cir. 1966).

The present case, therefore, is wholly unlike *Tileston* v. *Ullman,* 318 U.S. 44 (1943) (per curiam). There a physi-

cian, who claimed no rights whatsoever of his own, sought declaratory relief against a statute which prohibited *patients* from using contraceptives. Here, physicians are drastically affected by direct enforcement provisions of the challenged statute. Tileston, however, had made "no allegations asserting any claim under the Fourteenth Amendment of infringement of [his] liberty or his property rights." 318 U.S. at 44. It is abundantly clear that the physician sub-class

> "alleged such a personal stake in the outcome of the controversy as to assure that concrete adverseness which sharpens the presentation of issues upon which the court so largely depends for illumination of difficult constitutional questions." *Baker* v. *Carr*, 369 U.S. 186, 204 (1962), quoted in *Flast* v. *Cohen*, 392 U.S. 83, 99 (1968).

2. *Physician's Standing to Assert Patient's Right to Seek Medical Care*

The physicians also invoked the rights of their present, past, and prospective patients. A pregnant woman is generally in no position to undertake protracted litigation to establish her right to an abortion, and none has ever been prosecuted. Neither a physician's rights, nor those of his patients, should depend upon the ability to find a cooperative martyr, to be indicted as a principal.

This case, then, is a close parallel to *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), because

> "[t]he rights of [patients] are likely to be diluted or adversely affected unless those rights are considered in a suit involving [physicians] who have this kind of confidential relationship to them." 381 U.S. at 479,

Similarly, it has been held in abortion prosecutions that the physician may assert his patient's rights, a proposition which the lower court correctly accepted, and *California* v. *Belous*[26] considered so self-evident as to justify no more than a footnote. In fact, each federal and state court decision in recent months has concluded, without the need for extensive discussion, that physicians in both declaratory and defensive actions have standing to assert the rights of patients. *E.g., United States ex rel. Dr. Jesse Williams, II* v. *Zelker*, —— F.2d ——, No. 35381 (2d Cir. July 2, 1971) (Tom C. Clark, J.); *Crossen* v. *Breckenridge*, —— F.2d ——, No. 20852 (6th Cir. June 23, 1971) (Miller, J.). *See also Truax* v. *Raich*, 239 U.S. 33 (1915); *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); *see generally* Sedler, *Standing to Assert Constitutional Jus Tertii*, 71 YALE L.J. 599 (1962).

Physicians, in light of their direct involvement in the day to day effects and enforcement of the statute, are situated in much the same way as the defendant-covenantor in *Barrows* v. *Jackson*, 346 U.S. 249 (1953), because here as there "it would be difficult if not impossible for the persons whose rights are asserted to present their grievances before any court." 346 U.S. at 257. In any medical context it is meaningless to speak of physicians without patients and patients without physicians. In law it would be equally meaningless to hold that a physician may not rely upon her or his patients' rights.

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[26] 71 Cal.2d 954, 963 n. 5, 458 P.2d 194, 199, 80 Cal. Rptr. 354, 359 (1969) ("Dr. Belous' standing to raise this right is unchallenged."), *cert. denied*, 397 U.S. 915 (1970).

B. The drastic regular and recurring impact of the statute upon physicians and their patients poses a continuing case or controversy, which is ripe for adjudication, because physicians are deterred and hampered by the statute in advising and treating their patients, and repeatedly compelled to refuse to provide medical care out of a reasonable fear of enforcement of the statute.

"There can be little doubt that fear of the law is a determining factor in the policy adopted by hospitals and surgeons, both in the United States and in Great Britain." G. WILLIAMS, THE SANCTITY OF LIFE AND THE CRIMINAL LAW 168 (1966). Medical professionals, commendably, do not habitually flout laws in order to contest their validity. This Court, and lower courts, should not force such anti-social conduct by taking an unduly narrow view of the Article III case or controversy requirement, as was done by the lower court. Nothing in Article III, prior decisions by this Court, or considerations of judicial management remotely suggests that a physician must flout a statute and risk fines, imprisonment, and license revocation in order to challenge a law which poses concrete cases and controversies in the physician's office day after day.

The nature of the recurring case or controversy produced by the challenged statute is understandable, specific, and fully manageable within sound judicial procedures. Physicians do not simply "'feel inhibited'" by the restrictions on reasons and procedures for medical abortions in Georgia. *See Younger* v. *Harris,* 401 U.S. 37, 42 (1971). They *are inhibited* in a very serious, plainly demonstrable, concrete, and specific manner.

Georgia, and to a similar degree eleven other states, have singled out for criminal sanctions the medical procedure of abortion, separating it from all other procedures.

This in itself is a threat to physicians whose patients over a period of time may include hundreds who request abortions for valid personal reasons not covered by the law.

Georgia has enacted a special criminal statute which a physician must obey when processing applications for medical abortion. Otherwise he risks license revocation, fines, and imprisonment. These sanctions do not exist for other medical procedures.

While it is not incorrect to state that "whether a particular operation is necessary for a patient's physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered," *United States* v. *Vuitch*, 402 U.S. 62, 72 (1971), this does not terminate what must be a more searching inquiry. A decision reached between Scylla and Charybdis, or "under the Sword of Damocles," *Doe* v. *Randall*, 314 F. Supp. 32, 36 (D. Minn. 1970) (Neville, J., concurring), is qualitatively different from one of proceeding with a routine appendectomy.

Performance of even the most perilous surgery does not require approval by three examining physicians and *ex parte* rehearing *de novo* before a special hospital committee. More importantly, in no other sphere of medical practice could a physician perform a medical procedure believed to be in the patient's best interests and requested by the patient, complete the treatment with total satisfaction to himself and the patient, and nonetheless face license revocation and ten years in state prison, indeed ten years per patient.

The difference between routinely evaluating the need for requested surgery, and applying the Georgia law on medically-induced abortion, lies in the wide-ranging and irrec-

oncilable points of view among physicians as to when a patient "deserves" an abortion, the novelty of the law, the severe penalty provision, and the unique impact upon the physician-patient relationship of such laws.

Traditionally, the medical profession has been subject only to generalized limitations upon the scope of patient treatment. First, the physician must undertake necessary training and secure by license the right to practice his profession. This license is general in terms, and removes the physician from scrutiny by the criminal law in his treatment of patients.[27] State medical licensing laws are uniformly upheld, as in *Dent* v. *West Virginia*, 129 U.S. 114 (1889). The rationale for limited legislative intervention in the complex sphere of medicine is reasonable and not difficult to discern. As stated by Mr. Justice Field in *Dent*:

> "Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which life and health depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relationship to each other, as well as their influence upon the mind." 129 U.S. at 122.

Even with respect to the dispensing of hard narcotics, legislatures have never sought to prescribe the patient's symptoms which justify treatment and those which do not, much less to require treatment only in a particular type of medical facility. In fact, *Young* v. *United States*, 315 U.S. 257 (1942), construed the Harrison Narcotic Act to

[27] An obvious exception would be wanton and reckless misconduct.

exempt altogether "physicians administering to patients whom they personally attend." 315 U.S. at 259. No inquiry was to be made into the complexities of diagnosis and treatment.

With respect to the medical abortion procedure, however, physicians could reasonably anticipate criminal and administrative sanctions if they engaged in the ordinary practice of medicine. Normally a physician only seeks consultation for specialized problems. For abortions, he must call in an additional two examining physicians, *and* present his patient's case to a three or more member hospital abortion committee. With other surgery he would simply schedule the operating room for a given hour.

In ordinary medical practice, some procedures are done in the physician's clinic, some perhaps as a volunteer in a public free clinic, and others in a hospital, which may or may not be accredited by the Joint Commission on Accreditation of Hospitals [hereinafter JCAH]. With respect to medical abortion, however, the JCAH-accredited hospital is the sole institution authorized by Georgia law to permit abortions. The law further permits hospital owners to refuse to allow any abortions at all, regardless of the types of other comparable surgery normally undertaken there.

The low rate and maldistribution of medical abortions in Georgia, the very fact that this lawsuit was joined in by a physician subclass, and the severity of penalties which a physician might incur by violating the statute or hospital rules, are evidence of "a specific live grievance." *Golden v. Zwickler*, 394 U.S. 103, 110 (1969). While the lower court did not find a case or controversy between the physician subclass and state officials, that conclusion was unaccom-

panied by explanation. By contrast, federal courts in Wisconsin,[28] Texas,[29] Colorado,[30] Illinois,[31] North Carolina,[32] and Ohio[33] have faced the same questions of pre-indictment case or controversy, and ruled in the manner suggested by *Amici*.

It is not the province of a physicians' brief for *Amici Curiae* to undertake a lengthy review of this Court's decisions in the ripeness and case or controversy field. As *Amici*, physicians note, however, that prospective lawyers are not required to be disbarred or refused admission to the bar in order to contest statutes which affect the conduct of law students. *LSCRRC* v. *Wadmond*, 401 U.S. 154, 158-59 (1971). The teachers in *Epperson* v. *Arkansas*, 393 U.S. 97 (1968), and *Baggett* v. *Bullitt*, 377 U.S. 360 (1964), did not face a court-imposed dilemma forcing them to flout an anti-evolution statute in the Scopes tradition, or risk entanglement in a perjury prosecution which might follow the signing of a loyalty oath. The Scopes trial was an exciting event. Abortion prosecutions are another matter altogether. Only two physicians in Anglo-American history have had sufficient courage to choose the latter route. *See Rex* v. *Bourne* [1939] 1 K.B. 687; *Hodgson* v. *Randall*,

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[28] McCann v. Babbitz, 310 F. Supp. 293 (E.D. Wis.) (per curiam), *appeal dismissed*, 400 U.S. 1 (1970) (per curiam).

[29] Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970) (per curiam), *juris. postponed to merits*, 402 U.S. —— (May 3, 1971) (No. 70-18, 1971 Term).

[30] Doe v. Dunbar, 320 F. Supp. 1297 (D. Colo. 1970).

[31] Doe v. Scott, 321 F. Supp. 1385 (N.D. Ill.), *appeal docketed sub nom.* Hanrahan v. Doe, 39 U.S.L.W. 3438 (U.S. Mar. 29, 1971) (No. 70-105, 1971 Term).

[32] Corkey v. Edwards, 322 F. Supp. 1248 (W.D.N.C.), *appeal docketed*, 40 U.S.L.W. 3048 (U.S. July 17, 1971) (No. 71-92, 1971 Term).

[33] Steinberg v. Brown, 321 F. Supp. 741 (N.D. Ohio 1970).

314 F. Supp. 32 (D. Minn. 1970), *aff'd mem.*, 402 U.S. — (May 17, 1971). In neither instance was the recurring conflict between the physician's duty to the patient, and the physician-citizen's obligation to obey the law, resolved by defense of criminal charges.

Similarly, the drug companies in *Abbott Laboratories* v. *Gardner*, 387 U.S. 136 (1967), were permitted by this Court to make a broad attack on labelling regulations promulgated by the Commissioner of Food and Drugs. Physicians, even more than drug companies, "deal in a sensitive [profession], in which public confidence," 387 U.S. at 153, is especially important.

Indeed, even the earlier "ripeness" cases which found no controversy support the presence of a sufficient degree of justiciable adversity on the facts presented here.[34]

A bare majority in *Poe* v. *Ullman*, 367 U.S. 497 (1961), for example, found no controversy over the unenforced Connecticut law against the use of contraceptives. Justice Frankfurter's plurality opinion relied upon four factors: (1) a history of non-enforcement of the statutes against physicians and patients. 367 U.S. at 501-02; (2) the fact

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[34] The present action recalls the election cases where judicial review was sought too late, but underlying issues would recur again and again. As the Court stated in *Moore* v. *Ogilvie*, 394 U.S. 814, 816 (1969), "[t]he problem is . . . 'capable of repetition, yet evading review,' *Southern Pacific Terminal Co.* v. *ICC*, 219 U.S. 498, 515. The need for its resolution thus reflects a continuing controversy. . . ." And so it is here. Physicians seek to challenge the full statutory scheme on its face, and as applied in recurring kinds of cases. The problem here is repeated on a scale far exceeding that of recurring four-year presidential elections.

This is not a case like *Hall* v. *Beals*, 396 U.S. 45 (1969) (per curiam), where no continuing injury whatsoever was present. Nor is *Brockington* v. *Rhodes*, 396 U.S. 41 (1969) (per curiam), pertinent. There the relief sought was limited in nature and rendered impossible to grant by the passage of time.

that "contraceptives are commonly and notoriously sold in Connecticut stores. Yet no prosecutions are recorded. . . ." 367 U.S. at 502; (3) the absence of "real threat of enforcement," 367 U.S. at 507; and (4) the failure to find "deterrent effect . . . grounded in a realistic fear of prosecution." 367 U.S. at 508.

Each of these features is different in the present case, and additional considerations make this case even more appropriate for decision, on the merits.

(1) Physicians can easily document the fact that abortion statutes are regularly enforced by criminal prosecutions and license revocations. In addition, hospital committees in effect enforce the laws within their institutions. Neither *Poe* nor *Griswold* indicated that hospital committees in Connecticut regulated the prescription of contraceptives to patients.

(2) Abortions in Georgia's hospitals are obviously not "commonly and notoriously" available upon request.

(3) There is more than "real threat of enforcement" of Georgia's abortion laws. There is frequent actual enforcement at the administrative level of decision making.

Georgia residents from July to December, 1970, were 27th nationally in abortion-to-birth ratios. Approximately 67% were forced to leave the State for treatment. *See* APPENDIX B, *infra*, Figure I-2, at B-7. From July 1, 1970 to March 31, 1971, a total of 838 Georgia residents obtained legal abortions in *New York City*. Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (report released by Health Services Administration, City of New York).

The above analysis considers the *Poe* plurality opinion in isolation and assumes the case was correctly decided.

However, *Poe* was handed down over persuasive dissents by Justices Harlan and Douglas, and memorandum notations of dissent from Justices Stewart and Black. *Poe* has been repeatedly criticized and suggestions made that it be or was limited to its facts.[35] These criticisms largely derive from the sentiment that no civilized legal system should require an honest citizen to risk prison and disgrace to test the constitutionality of a statute.[36]

Poe appears to be one of the exceedingly few decisions which requires a litigant to invite and undergo criminal prosecution. Ultimately, the physicians prevailed, seven-to-two, four years later. Suppose they had not? The *Poe* decision would have consigned them to accepting the penalty. Other decisions, as Justices Harlan and Douglas pointed out, dissenting in *Poe*, imposed no such Hobson's choice.[37]

Justice Harlan's dissent in *Poe* undertook at length to demonstrate that the majority was in substantial error. 367 U.S. at 522-39. The Justice placed chief reliance on *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), and *Truax* v. *Raich*, 239 U.S. 33 (1915). Both permitted anticipatory relief to avoid damage caused by the present *effect* of a

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[35] *See* A. BICKEL, THE LEAST DANGEROUS BRANCH 143-55 (1962); Note, 62 COLUM. L. REV. 106 (1962); Comment, 50 CALIF. L. REV. 137 (1962). For an excellent general discussion of the "ripeness" question in the context of criminal law, see Note, *Declaratory Relief in the Criminal Law*, 80 HARV. L. REV. 1490 (1967).

[36] A corollary is the not infrequent condemnation of those who flagrantly break a law to test its validity.

[37] After Thomas Hobson (1544-1631), of Cambridge, England, who rented horses, but gave customers only the horse nearest the door. Here the physician must often choose between sending the patient out the door, or being taken out himself by law enforcement officers.

statute rather than imminence of enforcement. Significantly, in *Pierce*

> "a Court which included Justices Holmes, Brandeis, and Stone rejected a claim of prematureness and then passed upon and held unconstitutional a state statute whose sanctions were not even to become effective for more than seventeen months after the time the case was argued. . . ." *Poe* v. *Ullman,* 367 U.S. 497, 538 (1961) (Harlan, J., dissenting).

See also West Virginia Board of Education v. *Barnette,* 319 U.S. 624 (1943) (students allowed to challenge possible expulsions prior to actual dismissal, and prior to effective date of rule which, if enforced, would have required expulsion); *Terrace* v. *Thompson,* 263 U.S. 197, 216 (1923) ("They are not obliged to take the risk of prosecution, fines and imprisonment and loss of property in order to secure an adjudication of their rights").

Moreover, Congress, in passing the Declaratory Judgment Act, recognized the need to provide a federal anticipatory remedy in lieu of defense to a criminal prosecution. A Senate Report reflected this specific concern:

> "It is often necessary, in the absence of the declaratory judgment procedure, to violate or purport to violate a statute in order to obtain a judicial determination of its meaning or validity." S. Rep. No. 1005, 73d Cong., 2d Sess., at 2-3.

In the instant case, physicians positively refrain from treating and advising patients for the reason that they fear criminal prosecution, or administrative sanctions. They are not uninterested citizens urging an academic

question, but are a class of citizens greatly affected and deterred by the challenged statutes. As Professor Bickel suggested, in a slightly different context, "it may be true that by hypothesis no more suitable case can ever be constructed, because those who are unjustifiably deterred will never be prosecuted, and what deters them is precisely the prospect of litigation." [38]

In light of the considerations set out above, the lower court erred in dismissing claims of the physician subclass for want of a case or controversy.

C. Injunctive relief was necessary to prevent inevitable grave and immediate injury to physicians and their patients, because defense of criminal and/or administrative proceedings in a single case could not eliminate the recurring controversy, and the mere fact of such a state proceeding would drastically invade the physician-patient relationship, as well as exert an *in terrorem* effect upon the profession.

Amici, as physicians, can point to three substantial reasons why the lower court should have issued an injunction to enforce the extent of declaratory relief granted.

(1) First, the law is unclear on the extent to which state law enforcement authorities are bound by federal declaratory judgments pending appeal. There is authority that the Georgia courts would not have been bound by any aspects of the lower court's opinion, should officials have determined to institute state court proceedings against a physician. *See United States ex rel. Lawrence* v. *Woods*, 432 F.2d 1072 (7th Cir. 1970), *cert. denied*, 402 U.S. —— (May 17, 1971); *State* v. *Coleman*, 46 N.J. 16, 214 A.2d 393 (1965); *Iowa Nat'l Bank* v. *Stewart*, 214 Iowa 1229, 232 N.W. 445 (1930). Under such an interpretation, Georgia

[38] A. BICKEL, THE LEAST DANGEROUS BRANCH 149-50 (1962).

authorities would have been free to proceed against any physicians or hospitals that altered their practices.

The suggested dilemma is not fanciful. Under similar facts state officers in Wisconsin sought to defy and circumvent judgments by federal courts in two different districts of the state. *See McCann* v. *Babbitz*, 320 F. Supp. 219 (E.D. Wis. 1970) (per curiam), *vacated for reconsideration*, 402 U.S. 903 (1971); *Kennan* v. *Nichol*, —— F. Supp. ——, 71-C-118 (W.D. Wis. Apr. 27, May 5, 6, 1971).

An injunctive order removes any doubt about the rights of the respective parties, not only with respect to the scope of permissible conduct, but also concerning which party should appeal, and to what appellate court. The parties in Wisconsin made one trip to this Court only to learn that the attorney general had appealed to the wrong forum, as had the physician. *McCann* v. *Babbitz*, 310 F. Supp. 293 (E.D. Wis.) (per curiam), *appeal dismissed*, 400 U.S. 1 (1970) (per curiam).

(2) Where, as here, an injunction is needed to clarify the effect of a declaratory judgment, the order serves to avoid altogether the state-federal friction which might otherwise ensue. In many respects a bare declaratory judgment is an open invitation to state authorities to ignore the federal court at their option. By contrast, an injunction brings certainty and finality to the dispute, and at least discourages state officials from threatening or initiating any administrative or criminal proceedings or investigations. More importantly, an injunction *ab initio* obviates the possibility of a subsequent need to enjoin state court judges and proceedings under one of the express exceptions to 28 U.S.C. 2283 (1964 ed.). In this

sense, the injunction at the outset is sensible preventive medicine.

(3) The third reason for initial injunctive relief is to avoid the kind of grave irreparable injury which would befall physicians and their patients should the declaratory judgment be ignored at the administrative or any other level. There is no adequate remedy at law, or in the state courts, for a woman who is compelled to continue a pregnancy against her will. What was not undone by contraception, or by medical abortion in early pregnancy, or by spontaneous abortion in many cases, cannot be recompensed after birth. It is the unwilling mother who must accept the role of child-rearing for up to twenty years, not the legislators, and not the judges of the lower court.

By the same token, defense of a single criminal charge or license revocation proceeding would neither be an adequate forum in which to resolve the "continuing controversy between [physicians] and the State . . . ," *Perez* v. *Ledesma,* 401 U.S. 82, 102 (1971) (Brennan, J., concurring), nor an avenue that posed no threat of grave irreparable injury. If *Abbott Laboratories* means anything, it is that the mere fact of prosecution in a sensitive health-related industry is presumed to have disastrous consequences. Where, as in this case, the physicians present a straightforward legal issue, "the [statute] is directed at them in particular; it requires them to make significant changes in their everyday [professional] practices; if they fail to observe the [statute] they are quite clearly exposed to the imposition of strong sanctions," 387 U.S. at 154, then injunctive relief is both necessary and proper. Even more so is this the case, when one recalls that Abbott Laboratories, Inc., was a corporation asserting purely economic interests.

THE MERITS

II.

The provisions in Georgia Criminal Code §§26-1201, -1202(a)(1)-(3), -1202(b)(1)-(9), -1202(c), and -1202(e), which differentiate the medical procedures of therapeutic and elective induced abortion from all other forms of health care, deprive physicians of the fundamental personal right to administer to their patients, and patients of the right to seek medical care, in violation of the Due Process and Equal Protection clauses of the Fourteenth Amendment.

The statute in question undoubtedly restricts a physician in the practice of his profession. It limits his right to exercise his skills and apply his overall knowledge to the patient's benefit. By the same token, the statute deprives the patient of the right to seek health care in connection with the medical procedure of induced abortion.

The magnitude of the restrictions imposed by statutes such as the Model Penal Code-type abortion law is far reaching. As the co-reporter to the Code observed in a critical examination of its limitations, "[it] is not a question of restricting the freedom of a few eccentrics to avoid inflicting great psychic injury on the bulk of the population, but of restricting the freedom of scores of millions of citizens, having conflicting but equally respectable sensibilities to be protected." Schwartz, *Morals Offenses, and the Model Penal Code,* 63 COLUM. L. REV. 669, 683 (1963).

The contention of *Amici Curiae,* in full support of the Appellants in the case, is that the restrictions in the statute

as is necessary to preserve their health." The *Vuitch* decision went on to construe the term health to encompass "psychological as well as physical health," and " 'the state of being sound in body or mind.' "

The present case also has First and Fourteenth Amendment freedom of association implications, namely, the right of the physician to provide medical information, followed by treatment, for his patients, and the right of the patient to receive same. The right of a competent licensed physician to give medical advice can be characterized as free expression alone, or when viewed as an aspect of the physician-patient relationship, it becomes part of the freedom of association between physician and patient. The First Amendment has long been held to accord presumptive protection for the "freedom to associate and privacy in one's associations." *NAACP* v. *Alabama*, 357 U.S. 449, 462 (1958). This has been the case with the marital relationship,[39] and that of attorney and client.[40] The relationship between physician and patient is no different; it promotes the fundamental purpose of maintaining the health and well-being of the American people.

The advice aspect of medical practice is but one part of claim, for medical treatment involving interruption of the

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[39] *See* Griswold v. Connecticut, 381 U.S. 479, 486 (1965), describing the "marriage relationship" as

> "an association that promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects. Yet it is an association for as noble a purpose as any involved in our prior decisions."

[40] *See* NAACP v. Button, 371 U.S. 415 (1963); Brotherhood of Railway Trainmen v. Virginia, 377 U.S. 1 (1964); United Mine Workers v. Illinois State Bar, 389 U.S. 217 (1967); United Transportation Union v. State Bar of Michigan, 401 U.S. 576 (1971).

unwanted pregnancy may be what the patient ultimately requests, and the criminal statute proscribes.

> "[W]hen 'speech' and 'nonspeech' elements are combined in the same course of conduct, a sufficiently important governmental interest . . . must appear. . . ." *United States* v. *O'Brien*, 391 U.S. 367, 376 (1968).

The nature of this interest has been described by a "variety of descriptive terms: compelling; substantial; subordinating; paramount; cogent; strong." 391 U.S. at 376-77 (citations omitted).

The interests of patients must also be considered before examining the implementation of this law.

2. *Patients Have a Fundamental Right to Seek Health Care Which Includes the Treatment of Medical Abortion*

United States v. *Vuitch*, 402 U.S. 62 (1971), took the initial steps toward recognition of a right to seek medical treatment as a fundamental personal right protected by the Constitution. There this Court suggested a right of patients to "such treatment as is necessary to preserve their health."

While *Vuitch* had no need to hold, as a matter of constitutional law, that the right of access to health care was a fundamental personal right, such a holding in the present case would be judicially sound, and expressive of a manageable judicial principle.

Some measure of the recognition which nations give to the right of access to health care can be seen in the Constitution of the World Health Organization:

> "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." [41]

Congress, in passing the Comprehensive Health Planning Act of 1966, took a similar position:

> "[T]he fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living . . . ." [42]

The text of the Constitution supports this position by directly recognizing the rights to "life and liberty" in the Fourteenth Amendment. The term "life," in particular, was used in the 19th century in the manner that "life and health" are used today. As late as the 1880's Sir Joseph Lister's surgical techniques were only beginning to be used in the United States. " 'First Listerian operations' were still dotting the American surgical scene all through the eighties." H. CLAPESATTLE, THE DOCTORS MAYO 194 (1941). Only after Listerism gained a firm position in American surgery did non-emergency operations become feasible, not simply as "a last desperate throw of the dice with death, but a means of restoring *health* deliberately chosen in the early, curable stages of disease." *Id.* at 269 (emphasis added).

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[41] BASIC DOCUMENTS OF THE WORLD HEALTH ORGANIZATION 1 (Geneva 1969 ed.). *See also* Curran, *The Right to Health in National and International Law*, 284 NEW ENG. J. OF MEDICINE 1258 (1971).

[42] Public Law 89-749.

In addition to the decisions upholding rights associated with access to health care (and marital privacy), an overlapping body of precedent extends significant constitutional protection to the citizen's sovereignty over his or her own physical person.

As early as 1891 this Court stated:

> "No right is more sacred, [n]or is more carefully guarded . . . than the right of every individual to the possession and control of his own person, free from all restraint or interference of others unless by clear and unquestionable authority of law. As well said by Judge Cooley, 'The right to one's person may be said to be a right of complete immunity: to be let alone.'" *Union Pac. Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891),[43] quoted in *Terry* v. *Ohio*, 392 U.S. 1, 8-9 (1968).

This right, like all rights, has limits, as illustrated by *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1904). There the Court upheld a compulsory vaccination law, but only to avoid "great dangers" and to protect "the safety of the general public." 197 U.S. at 29. The lengths to which the Court went, however, to justify a shot in the arm, point up the degree to which personal autonomy in health matters is entitled to protection.

In family matters relating to child rearing and procreation, the Court has recognized and sustained individual rights on a constitutional plane. "The freedom to marry . . . ," *Loving* v. *Commonwealth*, 388 U.S. 1, 12 (1967); "the right to have offspring," *Skinner* v. *Oklahoma*, 316

[43] *Botsford* involved government coercion in forcing a medical examination.

U.S. 535, 536 (1942); "the liberty of parents and guardians to direct the upbringing and education of children under their control," *Pierce* v. *Society of Sisters,* 268 U.S. 510, 534-35 (1925); as well as the right, at least of a married woman, to use contraceptives, *Griswold* v. *Connecticut,* 381 U.S. 479 (1965), are all protected constitutionally.

Most recently the Court reaffirmed the "fundamental . . . right to be free, except in very limited circumstances, from unwanted governmental intrusions into one's privacy," *Stanley* v. *Georgia,* 394 U.S. 557, 564 (1969) (Marshall, J.), and embraced with approval Mr. Justice Brandeis' dissent in *Olmstead* v. *United States*:

> "The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the Government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized man." 277 U.S. at 478.

Chief Justice, then Circuit Judge, Burger, in *Application of Georgetown College, Inc.,* 331 F.2d 1010, 1016-17 (D.C. Cir.) (en banc), *cert. denied,* 377 U.S. 978 (1964), also urged a right to be let alone, in the context of a religious objection to blood transfusions, which could include "even absurd ideas which do not conform, such as refusing medical treatment even at great risk." 331 F.2d at 1017. If refusing health care might be constitutionally protected,

surely the right to seek health care for sensible reasons should enjoy equal or greater constitutional status.

Retired Justice Tom C. Clark has also suggested that constitutional concepts should include control over family planning beyond the stage of contraception. He wrote:

> "[A]bortion falls within that sensitive area of privacy —the marital relation. One of the basic values of this privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was found to prevent formation of the fetus. This, the Court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed?"[4]

B. The Equal Protection and Due Process clauses of the Fourteenth Amendment require that restrictive classifications in the challenged statute be narrowly drawn and supported by compelling state interests, in order not to abridge fundamental personal rights.

Several basic considerations have been articulated for the evaluation of competing interests in equal protection cases. One, which applies in matters of unique local interest involving taxes and business regulations, states:

> "Under traditional equal protection principles, a State retains broad discretion to classify as long as its classification has a reasonable basis." Blackmun, J., in *Graham* v. *Richardson,* 402 U.S., ——, —— (June 14, 1971).

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[4] Clark, *Religion, Morality, and Abortion: A Constitutional Appraisal,* 2 LOYOLA UNIV. (L.A.) L. REV. 1, 9 (1969) [hereinafter "Clark"].

However, a somewhat different technique is necessary when a "suspect classification" appears or important fundamental personal rights are threatened. As stated with respect to the fundamental personal right to travel in *Shapiro* v. *Thompson,* 394 U.S. 618, 638 (1969):

> "[T]he traditional criteria do not apply in these cases. Since the classification here touches upon [a] fundamental right . . . its constitutionality must be judged by the stricter standard of whether it promotes a *compelling* state interest." (Emphasis by the Court.)

This is also the case with the "suspect classification":

> "The classifications . . . are inherently suspect and are therefore subject to strict judicial scrutiny whether or not a fundamental right is impaired." *Graham* v. *Richardson,* 402 U.S. ——, —— (June 14, 1971).

In all cases, moreover,

> "a statutory discrimination must be based on differences that are reasonably related to the purposes of the Act in which it is found." *Morey* v. *Doud,* 354 U.S. 457, 465 (1957).

Stringent standards are more appropriate for the present case. These standards apply because the Georgia statute does more, far more, than regulate the medical procedure of abortion in the same way it might regulate some other medical practice, *i.e.,* by requiring that all clinics or hospitals obtain State licensure, or that all physicians obtain a license to practice.

The Georgia Therapeutic Abortion Act touches heavily upon the fundamental rights of physicians and patients.

Its classifications specify State-imposed "conditions" which a private physician and patient must satisfy to avoid criminal responsibility.

These "conditions" have no parallel in other medical procedures. They abridge the fundamental rights of some individuals by altogether prohibiting abortions for them, *i.e.*, women whose physical or mental health would be "seriously," but not "permanently" impaired by continuation of pregnancy, or "healthy" women who had contraceptive failure. The classifications make abortions exceedingly difficult for others to obtain, *i.e.*, those women in areas of Georgia where the only accredited hospitals refuse to do any abortions, or those who lack the financial resources to obtain psychiatric certification and cover hospitalization costs (barriers erected not by the patient, but by the State). Because of the statute's impact on *fundamental* rights, its classifications cannot stand unless supported by "a countervailing state interest of overriding significance." *Boddie* v. *Connecticut*, 401 U.S. 371, 377 (1971). Also, if any such compelling State interest is promoted by a classification, the class must not be unnecessarily restrictive. "'Precision of regulation must be the touchstone in an area so closely touching our most precious freedoms.'" *Griswold* v. *Connecticut*, 381 U.S. 479, 497, 498 (1965) (Mr. Justice Goldberg, concurring).

Here, a reading of the statute shows suspect classifications which impinge upon the marital relationship, as affected by the timing and spacing of children, *cf. Griswold* v. *Connecticut*, 381 U.S. 479 (1965); the personal interest in access to medical care, *cf. United States* v. *Vuitch*, 402 U.S. 62 (1971); the "human right" [not] "to have offspring," *cf. Skinner* v. *Oklahoma*, 316 U.S. 535, 536 (1942);

and the right announced as early as 1891 by Mr. Justice Gray (within limits) "to the control and possession of his [or her] own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Union Pac. Ry.* v. *Botsford,* 141 U.S. 250, 251 (1891). As to the latter, this Court only upheld the compulsory vaccination laws to avoid "great dangers" and to protect "the safety of the general public." *Jacobson* v. *Massachusetts,* 197 U.S. 11, 29 (1904) (Harlan, J.).

The stringent standards of review apply not only to the arbitrary features of the statute which appear *on its face,* but also to *applications and effects* of the statute which come about in practice.

C. The Georgia law on medical abortion, and similar laws in eleven other states, restrict access to this medical procedure in a manner which offends the Equal Protection clause of the Fourteenth Amendment.

It is settled that a law "applied and administered by public authority with an evil eye and an unequal hand, so as practically to make unjust and illegal discriminations between persons in similar circumstances, material to their rights [constitutes] the denial of equal justice . . . ." *Yick Wo* v. *Hopkins,* 118 U.S. 356, 373-74 (1886) (Matthews, J.). In several respects, the administration of the statute in question has created a patchwork of invidious discriminations.

1. *The "Health" Clause Is Interpreted Differently in Every State, Community, and Hospital, and Has Been Demonstrated to Be Without a Reasonably Specific Meaning*

Georgia's restriction on reasons for medical abortion, in words, is not so strict as the typical statute remaining in thirty jurisdictions. The standard pre-1967 prohibition forbade a woman to obtain an abortion "unless the same is necessary to preserve her life, or that of the child whereof she is pregnant . . . ." 40A MINN. STAT. ANN. §617.19, at 286 (1964); *accord,* 2A TEXAS PENAL CODE art. 1196, at 436 (1961). That is, a pregnancy may wreck a woman's physical health, create insuperable psychiatric difficulties, and leave her bedridden in Minnesota and Texas, but the laws require that she accept this burden, unless she aborts spontaneously.

In Georgia the burden is almost as severe. The woman and her physician must conclude that continued pregnancy would "seriously and permanently injure her health . . . ." GA. CRIM. CODE §26-1202(a)(1), at 85 (1969). If pregnancy *seriously* injures her health, that is not enough. If pregnancy *permanently* injures her health, that too is insufficient. Like the Eighth Amendment, the statute is in the conjunctive, not the disjunctive. For actual wording of the "health" justifications in the other eleven similar states, *see* APPENDIX B, *infra,* Table I-1, at B-1.

To some physicians and laymen, "health" means "physical survival." Permanent *and* serious injuries to "health" to them may mean inevitable lifetime invalidism, and nothing less.

To other physicians and laymen, "health" means "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." *Constitution*

of the World Health Organization, in BASIC DOCUMENTS OF THE WORLD HEALTH ORGANIZATION 1 (Geneva 1969 ed.). A "physically healthy" woman with no classic "mental health" problems such as neurosis, may nonetheless become a victim of rape or contraceptive failure, and find that termination of the pregnancy would enhance some additional category of her "mental health." Indeed, "for the healthy woman with a happy marriage, abortion is most often truly therapeutic." Walter, *Psychologic and Emotional Consequences of Elective Abortion,* 36 OBSTETRICS & GYNECOLOGY 482, 487 (1970).

It is not so much what "health" can mean, as the way such a term is used, whether as a reason for undertaking surgery, or a reason for declining to do so. With ordinary elective surgery, a physician seeks "health" reasons why the procedure should be done, *i.e.,* "indications," as well as "health" reasons why it should not, *i.e.,* "contra-indications." The two avenues of inquiry, moreover, may not at all overlap and may be altogether unrelated. For example, cosmetic surgery may be indicated as necessary to alleviate irrational self-doubt. However, the procedure may be contra-indicated in an unusual case by likelihood of uncontrollable blood loss.

If valid "indications" for a procedure are found, and these are not overcome by "contra-indications," the surgeon proceeds. The trouble with abortion statutes is that they reveal an understandable, but nonetheless substantial ignorance of how medicine is practiced. As much could be expected if physicians drafted statutes stipulating how attorneys should practice law. Attorneys would be required to do "justice" to their clients, particularly physician-clients, and failure to do so would result in ten years' imprisonment.

The practice of medicine is no more standardized than the practice of law. An instrument as blunt as the criminal law cannot begin to define and regulate "those subtle and mysterious influences upon which life and health depend . . . ." *Dent* v. *West Virginia,* 129 U.S. 114, 122 (1889).

Physicians differ widely in their evaluation of indications and contra-indications for medical abortion, probably more so than in any field of practice. Rather than avoiding abortion practice altogether, however, physicians with narrow concepts of indications remain on hospital committees and other bodies which affect or control the interpretation of abortion laws.[45]

A lawyer or judge, after reading the statute, can examine the medical literature to assess how the statute affects medical practice, and whether its implementation is arbitrary or discriminatory. The literature presents an unending array of scholarly medical analysis with careful explanations of how arbitrary, indefinite, and standardless abortion laws have been.

Retired Justice Tom C. Clark set a commendable medico-legal example in his full treatment of the very question presented in this section. According to Justice Clark:

> "The increasing number of abortions subjects physicians to increased dangers of liability for incorrectly interpreting a statute . . . . [D]octors face an uncertain fate when performing an abortion. This uncer-

[45] *Amicus* Dr. J. Robert Willson, a former president of the American College of Obstetricians, spoke volumes when he stated: "After all, legal abortion is controlled by individual hospitals, not by the state capitol." *Abortion—A Medical Responsibility?,* 30 OBSTETRICS & GYNECOLOGY 294, 302 (1967).

> tainty will continue unless the legislatures or courts provide relief from liability." [46]

Indeed, the commentators for the Model Penal Code provision on abortion, which in essence is under attack in this case, foresaw that "[p]sychiatric justifications for abortion are harder to classify and verify, and psychiatrists themselves have expressed concern at the shadowy line between medical and social justification." MODEL PENAL CODE §207.11, Comments, at 153 (Tent. Draft No. 9, 1959). The A.L.I. had "no body of experience," *id.* at 156, with reform abortion laws at that time and took no position on the need for further modifications of the Code. It appears that the A.L.I. has since been inactive on this subject.

The "body of experience" over the period from 1959 to date has been catalogued in the medical journals with increasing frequency and in growing volume. In response, both the American Medical Association[47] and the American College of Obstetricians and Gynecologists[48] have found Model Penal Code-type policies on abortion to be unworkable. In 1970 both organizations abandoned their previous Code-type approach for policies permitting the physician to consider the patient's entire family setting (without fear of reprimand for defining "health" more generously than his department chairman). Similarly, in 1970, the Second Tentative Draft of the UNIFORM ABORTION ACT eliminated previous listings of "health" reasons for abortion.[49]

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[46] Clark, *supra* note 44, at 7.

[47] *Abortion*, Proceedings of the American Medical Ass'n House of Delegates 47 (June, 1970); *see* 213 J. AMERICAN MEDICAL ASS'N 1242 (1970).

[48] *Policy on Abortion*, American College of Obstetricians and Gynecologists (Aug. 1970); Appendix A, *infra*, at A-1.

[49] UNIFORM ABORTION ACT (2d Tent. Draft, Aug. 1970).

One facet of experience has been to understand that concepts such as "health," "physical health," "mental health," "social conditions," and "patient's environment," are flexible abstract constructs, not a part of measurable scientific matter. Not one or two factors enter into a physician's judgment in assessing the "health" justifications for a medical abortion, but many; indeed, more than could be resolved in ten exercises of a state law remedy in state courts. Some of the questions which are not illuminated by the language and history of the Georgia statute are as follows:

(1) To what extent, if any, may "mental health" factors be considered?

(2) If only "physical health" factors are permissible, what kinds of physical injuries are contemplated by the statute?

(3) Are the dangers of physical injury brought on by mental response to unwanted pregnancy, *i.e.*, attempted suicide, self-mutilation, resort to quack or self-abortion, sufficient under the law?

(4) Must the pending physical injury be from a preexisting condition directly associated with the reproductive organs?

(5) If "mental health" factors are cognizable, must these be diagnosed by one or more psychiatric specialists, or is the private physician enough?

(6) To what extent, if any, may the two extra examining physicians rely upon the private physician's evaluation, as contrasted with their independent findings?

(7) By the same token, to what degree must the hospital committee conduct an independent evaluation?

(8) Is a history or pre-existing mental illness with confinement in an institution necessary?

(9) Is any history of prior psychological difficulty necessary?

These are not fine-spun, legalistic distinctions. The examples are taken from the lengthy medical literature on difficulties of administering the twelve A.L.I.-style abortion laws.

Illustrations from principal medical authorities and texts show that hospitals, their committees, department heads, and individual physicians interpret this type of statute in an impermissibly fluctuating manner. The consequence has been arbitrary and discriminatory implementation of access to this medical procedure.

Louis M. Hellman, M.D., co-author of the definitive text on obstetrics and gynecology, reviewed the recent experience as follows:

> "Because concepts are changing rapidly, the definition of therapeutic abortion lacks precision. The word 'health' in particular is variously interpreted. . . .
>
> In a time of rapidly changing laws, concepts, and mores, therapeutic abortion cannot be defined nor can the listing of its indications carry any degree of accuracy or permanence. • • •
>
> The reform of abortion laws along the guidelines drawn by the American Law Institute has not worked well. Although the number of abortions has increased markedly, the poor still find it difficult to obtain abortions even in situations of obvious merit." L. HELLMAN

& J. PRITCHARD, WILLIAMS OBSTETRICS 1085, 1087 (14th ed. 1971).

The then-Chairman of the Department of Obstetrics and Gynecology at the University of California School of Medicine, San Francisco, Edmund W. Overstreet, M.D., related a similar experience under the California therapeutic abortion law, which also is of the Model Penal Code variety:

> "[P]sychiatrists will vary greatly in their diagnosis of mental illness and the nonpsychiatric physician finds it even more difficult to decide whether or not a patient has mental illness to the point of [legally, not medically] justifying therapeutic abortion. . . .
>
> "[T]he adjudication of therapeutic abortion, especially the mental illness area (and that is 88 per cent of our cases at the present time), is uneven, inequitable, and discriminatory. No one is happy about it in California. No satisfactory guidelines are developing as to how to approach candidates for therapeutic abortion. Several studies going on now in California, and some of the Swedish results, suggest that forcing a woman to carry an unwanted pregnancy to term against her will always impairs her mental health." Overstreet, *Abortion and Obstetrics* (Panel), in II ABORTION IN A CHANGING WORLD 74-75 (R. Hall ed. 1970).

The intimation by Dr. Overstreet that deeply unwanted pregnancy *per se* in a "physically" healthy woman might impair her "mental" health has become the focal point of further studies which verify his suggestion. Today, much of the medical literature recognizes "the undeniable effects of sociological factors on an individual's mental health."

Pike, *Therapeutic Abortion and Mental Health*, 111 CALIF. MEDICINE 318, 319 (1969). *See generally* Hook, *Refused Abortion*, 37 ACTA PSYCHIAT 203 (1961).

Nonetheless, in this area of medicine, the physician-patient relationship is non-existent at the hospital committee level. There a woman may find her application blocked by a physician she has never seen who is "convinced that women have a need to give birth and urge[s] that there be no interference with their doing so." Crowley & Laidlaw, *Psychiatric Opinion Regarding Abortion: Preliminary Report of a Survey*, 124 AM. J. PSYCHIATRY 145, 147 (1967).

It would unduly lengthen this brief for *Amici* to point out the many additional studies on capricious and discriminatory administration of the type statute involved here. For the Court's reference, and to emphasize this important point, *Amici* are including excerpts from such studies below.[50]

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[50] Materials from medical and psychiatric literature which illustrate the wide-ranging interpretations of language in laws on abortion, and the sometimes arbitrary implementation of these laws include the following authorities:

(1) Hall, *Abortion in American Hospitals*, 57 AM. J. PUB. HEALTH 1933, 1935 (1967):

"Abortion policies vary not only from hospital to hospital but also from service to service within the same hospital. They also vary widely from doctor to doctor on the same service of the same hospital."

(2) M. CALDERONE, (ed.), ABORTION IN THE UNITED STATES 34-35, 52 (1958):

"[N]ecessity as a sine qua non of performing an abortion . . . leaves the doctor's position perilous and uncertain. • • • The current laws provide no accurate criteria by which the doctor can govern his actions."

(3) For a vivid illustration of the variations among California hospitals in assessing the legality of therapeutic abortion on

A final observation, however, should be that even the more prominent opponents of abortion reform acknowledged this statutory uncertainty. Father John T. Noonan, Jr., criticized the A.L.I. proposal's "physical or mental 'health'" terminology because "[t]here is nothing in the statute which would aid the physician in making the determination." Louisell & Noonan, *Constitutional Balance*, in THE MORALITY OF ABORTION 249 (Noonan ed. 1970). An earlier article by Professor Louisell stated: "'Mental

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a given set of facts, see the questionnaire study and analysis of results in Packer & Gampell, *Therapeutic Abortion: A Problem in Law and Medicine*, 11 STAN. L. REV. 417, 423 (1959). The study is discussed and relied on in *California* v. *Belous*, 71 Cal.2d 954, 972, 458 P.2d 194, 205, 80 Cal. Rptr. 354, 365 (1969).

(4) White, *Induced Abortions: A Survey of their Psychiatric Implications, Complications, and Indications*, 24 TEX. REPS. OF BIOLOGY & MEDICINE 531, 541 (1966):

"[T]he enormous variability in the frequency of therapeutic abortions from one hospital to another . . . must surely reflect, more than anything else, differences in the personal values, religious beliefs, and social ideology of the staffs of the respective hospitals about the matter of abortion."

(5) R. H. SCHWARZ, SEPTIC ABORTION 11 (1968):

"The legal status of abortion varies not only throughout the world but from state to state. Interpretation and enforcement differ from community to community; professional assessment varies from hospital to hospital, and from physician to physician."

(6) GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, THE RIGHT TO ABORTION: A PSYCHIATRIC VIEW 40 (Comm. on Law & Psychiatry, 1970):

"[T]he rate of therapeutic abortion varies dramatically from hospital to hospital within a state, even though all are supposedly governed by the same statutes."

(7) Russell & Jackson, *Therapeutic Abortions in California*, 105 AM. J. OBST. & GYN. 757, 762, 765 (1969):

"It is obvious that there exists wide variability in the application of the [statute]. . . . Variation exists from com-

health of the mother' is particularly nebulous and susceptible to subjective value judgments." Louisell, *Abortion, the Practice of Medicine and the Due Process of Law*, 16 U.C.L.A.L. REV. 233, 252 n. 83 (1969). Opponents of reform in North Carolina "attacked the vagueness of such

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munity to community, and from hospital to hospital within the same community.

Many factors have contributed to this state of affairs. Some of these are:

"1. A certain vagueness in what is intended, legislatively speaking, by 'mental' and 'physical' health. • • • [T]he definition of mental health is one of the most vague parts of an often vague piece of legislation."

(8) Droegemueller, Taylor & Drose, *The First Year of Experience in Colorado With the New Abortion Law*, 103 AM. J. OBST. & GYN. 694, 697 (1969):

"There is a great deal of variation in the interpretation of psychiatric indications. . . .

"The hospitals in the small and medium-sized towns are performing very few therapeutic abortions."

In addition to the above authorities, who stress variations from place-to-place and person-to-person, much research and analysis has examined some of the many reasons why physicians and psychiatrists have difficulty with the statutes, including specific aspects of confusion:

(9) Ryan, *Humane Abortion Laws and the Health Needs of Society*, 17 W. RES. L. REV. 424, 431 (1965):

"Distinctions between physical and mental health are meaningless in terms of modern medical thinking. Health cannot be divorced from socio-economic factors which influence people's lives since health is a product of these conditions."

(10) White, *supra* no. (4), at 532:

"[T]here are no generally accepted policies, little or no systematically gathered data, and remarkably few well and objectively substantiated points of view among psychiatrists about 'legally' or 'illegally' induced abortions."

(11) Pike, *Therapeutic Abortion and Mental Health*, 111 CALIF. MED. 318, 319 (Oct. 1969).

"One of the controversial aspects of the situation is the undeniable effect of sociological factors on an individual's

terms as . . . 'substantial risk,' 'gravely impair,' 'grave physical or mental defect' and urged greater precision. . . ." Jain & Sinding, *North Carolina Abortion Law 1967*, at 29 (Carolina Pop. Center 1968).

Further factors in the implementation of Georgia's law increase its irregular impact. The problem of construing

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mental health. The stress and consequences of an unwanted pregnancy as they affect mental health must be determined for an individual patient, taking into consideration her total life situation. Factors such as marital status, family support, economic conditions, subcultural attitudes toward the pregnancy, and personality structure all contribute toward her ability to maintain and complete her pregnancy without damage to her mental functioning.

The new law requires physicians to make judgments that are difficult to make, impossible to prove and of crucial importance to the patient's welfare and the welfare of those dependent on her and intimately involved with her."

(12) Sir Dugald Baird, *The Obstetrician and Society*, 60 AM. J. PUBLIC HEALTH 628, 635 (1970).

"[E]ven in a basically stable woman, emotional health and subsequently physical health can be undermined by adverse social conditions: for example, substandard housing, overcrowding, illness in other children, elderly or bedridden parents, alcoholic husband, and economic necessity for the mother to work outside the home."

(13) Thompson, Cowen & Berris, *Therapeutic Abortion: A Two-Year Experience in One Hospital*, 213 J.A.M.A. 991, 994 (1970):

"Psychiatric and socioeconomic problems are so intertwined that it is difficult for the Therapeutic Abortion Board to extract the relevant data in order to make a just and lawful decision. . . . In light of the previously stated vagueness of the law, the evaluation of the patient for psychiatric indications has been one of our major problems."

(14) Moyers, *Abortion Laws: A Study in Social Change*, 7 SAN DIEGO L. REV. 237, 241 (1970):

"Although some hospitals in the state have done away with the requirement, most committees still require psychiatric consultation when a request for abortion is presented on this [mental health] ground."

"health" rests not solely with her personal physician. Two additional examining physicians are required by the statute. Moreover, any conclusion reached by the first three physicians may be overturned by the hospital committee possibly composed of yet three more physicians, at a minimum. All of the uncertainties set out above are multiplied at this stage by the further examining and committee physicians. Putting to one side the extraordinary waste of highly skilled professional time consumed by this cumbersome ritual, the multiple physician evaluation has a common denominator effect. This is a particular problem in Georgia because "[m]aternal mental health indications are more restrictively defined by the medical community in Georgia than in other states with similar laws." Rochat, *et al.*, *An Epidemiological Analysis of Abortion in Georgia*, 61 Am. J. Public Health 543, 551 (1971).

The victim of this confusion is the patient, the very individual whose health interests should be of prime concern. Throughout the literature on discriminatory implementation of abortion laws, mention of her is slight or nonexistent. Under the statutory language, her health interests are penultimate. In practice, her interests are secondary to state and county lines, hospital quotas, professional disputes among schools of psychiatric philosophy, and a host of sub-conscious motivating factors present in the individuals who stand between her and her private physician. In short, to obtain a medical abortion in Georgia and similar states, a patient must find physician A, sympathetic examining colleagues B and C, cooperative JCAH-accredited hospital D, in county E, a sympathetic committee of physicians F, G, and H at the hospital, and personal patience of an exceptional variety.

2. *Widespread discrimination on the basis of a patient's place of abode has resulted from the statute and its uneven administration*

None of the barriers described above stand between a physician and patient with respect to any other medical procedure, not even organ transplants or brain surgery. It is no statistical aberration that 67% of the Georgia residents who obtained legal medical abortions between July and December, 1970, did so *in another state.* APPENDIX B, Figure 1-2, *infra,* at B-5, 6. A total of 838 Georgia residents obtained legal abortions in New York City alone as of March 31, 1971. Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (report released by Health Services Administration, City of New York). The figure of 838 for nine months extrapolates to 1,117 for twelve months. This compares with the 1968-1970 in-state Georgia total of 939 legal abortions, for almost three full years (April 12, 1968 to December 31, 1970; 2.72 years), or 1,035 for three years as extrapolated. In short, New York City physicians provided legal medical abortions for more Georgia residents in one year than Georgia itself has permitted in three years.

Abortion may be a recent subject insofar as litigation is concerned, but the data presented here reveal the same kinds of discriminations dealt with forcefully in the past by this Court. One need only review a few of the decisions on jury selection,[51] voting rights,[52] and legislative malapportionment.[53] In every area wherein the rights of any

[51] *E.g.*, Swain v. Alabama, 380 U.S. 202 (1965).

[52] *E.g.*, Harper v. Virginia Board of Elections, 383 U.S. 663 (1966).

[53] *E.g*, Gray v. Sanders, 372 U.S. 363 (1963); Reynolds v. Sims, 377 U.S. 533 (1964).

American citizen are abridged for arbitrary reasons, "figures speak and when they do, Courts listen . . . ." *Brooks* v. *Beto*, 366 F.2d 1, 9 (5th Cir. 1966). This has increasingly been the case with respect to important personal needs, particularly where the State exercises monopolistic control over access to the means to vindicate the need. *E.g., Boodie* v. *Connecticut*, 401 U.S. 371 (1971); *Hawkins* v. *Town of Shaw, Mississippi*, 437 F.2d 1286 (5th Cir. 1971).

Data on the availability and distribution of legal medical abortion in Georgia and other A.L.I. states reveal an arbitrary and discriminatory pattern inherent in the statutes themselves. This has been the studied concensus of proponents and opponents of abortion reform alike, and is verified by available data.

Tables I-2, II-A & III-A, supplemented by Figures II-A-1 & II-A-2, APPENDIX B, *infra*, at B-5, 6, *et seq.*, shows the numbers of legal abortions by county in Georgia, and the distribution within the state.

Georgia is a state with 159 counties. However, only 56 counties have a JCAH-accredited hospital, while 103 (65%) do not. Although only 38% (5/13) of the metropolitan counties[54] lack JCAH-accredited facilities, a full 67% (98/146) of rural counties are without facilities authorized to do legal abortions. Even more significant is the fact that 96% (153/159) of Georgia's counties had 10 or fewer legal abortions in the most recent year, 1970. 54% of the metropolitan counties had fewer than 10 legal

[54] The standard definition of "metropolitan county" is one containing at least one city of 50,000 or more inhabitants, or a county integrated with such a city in a neighboring county. Figures are based on the 1960 census data. *See* I U.S. Bureau of the Census, *Census of Population* ch. A (1960).

abortions in 1970, but a full 100% of the rural counties had fewer than 10. Of the 150 Georgia hospitals which are licensed by the State, 79 (53%) are not JCAH-accredited, and accordingly not permitted to perform legal abortions. 71 of these 79 are in non-metropolitan counties.

Data from the other A.L.I. states, where available, have been included in the additional tables and charts which make up Appendix B to this brief. These show a comparable state of affairs in other jurisdictions which are operating under the Model Penal Code-type statute. *See* APPENDIX B, *esp.* Table 1-2, *infra,* at B-5, 6.

The ratio of legal abortions to births, which is a rough measure of the availability of abortion, varied from a 4.0 low in Georgia to a 194.2 high in California, although both have essentially the same statute.

The percentages of counties in A.L.I. states wherein fewer than 10 legal abortions were performed in 1970 exceeded 50% in eight of the ten states for which data were available: Georgia (96%), South Carolina (85%), North Carolina (79%), Virginia (91%), Maryland (68%), Colorado (86%), New Mexico (78%), and Oregon (53%).

These figures point to a systematic pattern of discrimination. In practice the A.L.I. statute excludes an extraordinarily disproportionate number of: (1) rural patients; (2) patients lacking sufficient access to any family planning measures at all, and funds for a legal medical abortion when needed; (3) patients lacking access to the few hospitals and physicians who are most sympathetic to legal abortion; (4) black patients who, as a class, are more economically deprived in Georgia, for example,

and account there for 88% of the non-medical abortion deaths (1965 to date). Rochat, *et al., An Epidemiological Analysis of Abortion in Georgia,* 61 Am. J. Public Health 543 (1971).

As to these classes of patients, their entitlement to scrupulous judicial scrutiny of the statute's effects is particularly well-established. Not only do they suffer in the inability to exercise the fundamental personal rights described previously, but they are also denied access to medical abortion on grounds of: (1) place of residence; (2) financial status; (3) lack of information; and (4) race.[55] As physicians, *Amici* contend that such factors should have no bearing upon an individual's entitlement to medical care.

Discrimination against persons on the basis of place of residence has been uniformly condemned, provided that factor had no relevance to the person's status in relation to the particular law. The medical data in this case show vast disparities in access to medical care from county-to-county and hospital-to-hospital. Patients are the victims of this disparity. In the same way that "white children" had "accredited schools" in Prince Edward County, *Griffin* v. *County School Board,* 377 U.S. 218, 230 (1964) (Black, J.), white, urban, and affluent patients have access to JCAH-accredited medical facilities in urban Georgia. The State imposes the JCAH requirement, forbids rural non-JCAH hospitals to offer this single medical procedure, and permits even the JCAH general community hospital governing boards to forbid entirely the medical procedure of abortion.

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[55] Other arbitrary classifications in the statute are examined *infra,* such as the structures on medical justifications for abortion, the limitation to JCAH-accredited hospitals, and the requirement of residency.

In *Griffin* and the reapportionment cases this Court held that persons "cannot be classified, constitutionally, on the basis of where they live . . . ." *Reynolds* v. *Sims*, 377 U.S. 533, 560 (1964). The cumulative effect of the restrictions on medical abortion in Georgia, however, accomplishes this forbidden result. By statute Georgia creates the obstacles which inherently work to the disfavor of rural physicians and their patients.[56] While it is commendable that at least this discrimination may not have been foreseen, or

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[56] In light of the fact that the rural counties in Georgia have 81% of the State's hospitals, and account for 42% of births, it cannot be maintained that the rural discrimination results from lack of facilities, or other special rural characteristics.

Discrimination based on location within the state has frequently been held to violate the Equal Protection clause. *See, e.g.*, Avery v. Midland County, 390 U.S. 474, 480 (1967) (White, J.):

> "A city, town, or county may no more deny the equal protection of the laws than it may abridge freedom of speech. . . ."

Hawkins v. Town of Shaw, Mississippi, 437 F.2d 1286, 1292 (5th Cir. 1971):

> "[N]o compelling state interests can possibly justify the discriminatory *results* of Shaw's administration of municipal services. . . ." (Emphasis in original.)

Long v. Robinson, 316 F. Supp. 22, 27 (D. Md. 1970), *aff'd*, 436 F.2d 1116 (4th Cir. 1971):

> "[T]here is no psychological or physical basis for distinguishing between sixteen and seventeen year olds residing in Baltimore City and in the Counties."

Sams v. Ohio Valley General Hospital Ass'n, 413 F.2d 826, 827 (4th Cir. 1969):

> "[W]ithout semblance of reason for the differentiation, these hospitals accord full participation to doctors with offices and practices *within Ohio County* but refuse the same entitlement to those not so classifiable." (Emphasis added.)

Clayton v. North Carolina State Bd. of Elections, 317 F. Supp. 915, 920 (E.D.N.C. 1970):

> "[N]o evidence has been adduced to show why the *six counties* should be *treated differently* from the other ninety-four with

"thoughtless," [57] the lack of overt invidious intent is of little consolation to the poverty-stricken rural mother of ten who is facing her eleventh pregnancy. The Constitution forbids "sophisticated as well as simple-minded modes of discrimination. It hits onerous procedural requirements which effectively handicap exercise of the [right in question]. . . . " *Lane* v. *Wilson*, 307 U.S. 268, 275 (1939) (Frankfurter, J.).

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respect to the distance from the polling place at which electioneering may lawfully be conducted." (Emphasis added.)

Orr v. Thorp, 308 F. Supp. 1369, 1372 (S.D. Fla. 1969):

"[D]efendants have made no effort to demonstrate that Palm Beach County is in any way unique so as to justify placing its educational employees in a class apart from those of other Florida counties."

Richards v. Townsend, 303 F. Supp. 793, 795 (N.D. Calif. 1969):

"The equal protection clause applies not only to unreasoned distinctions based on race or relative affluence, but also to those based on accidents of geography."

Alabama State Teachers Ass'n v. Lowndes County Bd. of Education, 289 F. Supp. 300, 304-05 (M.D. Ala. 1968):

". . . Alabama denied the benefits of the teacher tenure law to eight counties which, with one exception, are among the twelve counties in this State having a preponderantly Negro population."

See also Canale v. Steveson, —— Tenn. ——, 458 S.W.2d 797 (1970) (statute prohibiting fortune-telling in counties of more than 400,000 population invalid); State v. Fowler, 193 N.C. 290, 136 S.E. 709 (1927) (statute punishing illegal manufacture of alcohol in six counties with fine, while imposing imprisonment elsewhere, held invalid); State v. Swegori, 318 Mo. 998, 2 S.W.2d 747 (1924) (statute setting juvenile court jurisdiction at 17 for some counties and 18 for others, held invalid).

[57] *See* Norwalk CORE v. Norwalk Redevelopment Agency, 395 F.2d 920, 931 (2d Cir. 1968):

"[T]he arbitrary quality of thoughtlessness can be as disastrous and unfair to private rights and the public interest as the perversity of a willful scheme."

If it be objected that *Lane* and *Reynolds* involved the right to vote, and *Griffin* the right to go to school, then *Amici* can only respond that the rights to medical care and autonomy of the family are "older than the Bill of Rights—older than our political parties, older than our school system." *Griswold* v. *Connecticut*, 381 U.S. 479, 486 (1965).

A second suspect classification resulting from the statute is the discrimination made between the patient with means, and the patient with none. This is a far-reaching defect of most abortion legislation, and appears to be inherent in the statute, rather than an inadvertent consequence of differences in personal wealth. This issue is discussed in the able brief filed by counsel for the OEO National Legal Program on the Health Problems of the Poor. These *Amici* will not duplicate that effort.

The socio-economic and racially discriminatory aspects of this type of legislation are also covered by the OEO brief. It is sufficient for *Amici* to confirm that this kind of legislation has built-in hurdles for patients to overcome, which cannot be surmounted without time, information, sophistication, and the ability to pay additional sums for consulting physicians and hospital stays. Georgia makes no such imposition upon patients for any other medical procedure.

In concluding this discussion of the various arbitrary and discriminatory features of Georgia's abortion law, *Amici* contend that this in itself is adequate justification for invalidating the entire statutory scheme. Georgia could then start anew, with an obligation to avoid regulation, except for overriding reasons, which themselves must be reflected in narrowly drawn statutes. Thus it might be

that the State could enact comprehensive family planning legislation, emphasizing thorough public education, extensive programs of contraception and where requested, sterilization. All hospitals could be encouraged to make legal medical abortion available as a back-up measure for contraceptive failure or nonuse, and the State, through administrative action, could make funds and technical assistance available to this end.

Under the present state of affairs, medical abortion in Georgia is available to the individuals with means. Those without knowledge, sophistication, funds, and political power, are also largely without access to legal abortion.

D. The provisions in Georgia Criminal Code §§26-1201, -1202(a) (1)-(3), -1202(b) (1)-(9), -1202(c), and -1202(e) are not narrowly drawn and do not advance a compelling state interest

The previous section established that the Georgia law regulating the medical procedure of induced abortion, *as applied* and implemented, was inconsistent with the Equal Protection clause of the Fourteenth Amendment. Similarly, the statute favors certain classes of patients, and excludes others, *on its face* in a manner offensive to Equal Protection concepts.

Four types of classifications appear invalid. These will be taken up seriatim.

1. The limitation of medical justifications to cases in which: (1) continuation of pregnancy would "endanger the life" of the woman, or "seriously and permanently injure her health," or (2) "[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect," or (3) "[t]he pregnancy resulted from forcible or statutory rape," is neither narrowly drawn nor supported by any compelling state interests

Essentially three reasons are permissible for the medical procedure of abortion under Georgia law. These occur when the patient can persuade three physicians, the JCAH-hospital abortion committee, and other required signatories that:

(1) "continuation of the pregnancy would . . . seriously and permanently injure [their] health . . .", or

(2) "[t]he fetus would very likely be born with a grave permanent and irremedial mental or physical defect," or

(3) "[t]he pregnancy resulted from forcible or statutory rape."

The equal protection inquiry with regard to the *reasons* said to justify legal medical abortions must begin with asking who are excluded, and why? As seen earlier, the classifications herein are suspect. Moreover, they must be "based on differences that are reasonably related to the purposes of the Act. . . . " *Morey* v. *Doud,* 354 U.S. 457, 465 (1957).

The *excluded* class of legal abortion applicants is difficult to describe, particularly in light of the varying interpretations given to the statute from county-to-county and hospital-to-hospital. However, an approximation of those

whose reasons for abortion do not fit into the statutory justifications would be the patients in whose cases:

(1) continuation of pregnancy would *seriously, but not permanently* injure their health, or

(2) continuation of pregnancy would *permanently, but not seriously* injure their health, or

(3) continued pregnancy would injure their physical or mental health to some degree not deemed both serious *and* permanent by the certifying authorities, or

(4) continued pregnancy would have damaging effects upon the family unit, the husband, or other children, or

(5) continued pregnancy would disrupt the family plan of limiting the number of children to those already existing, or

(6) any other case in which both physician and patient agree that no valid medical reasons exist for not going forward with the abortion requested by the patient, in that her overall well-being would be enhanced thereby.

a. The limiting provisions are not rationally related to a public health interest

On pages 10 to 13 of this brief, *Amici* set forth the data on safety aspects of medical abortion. These data indicated that mortality rates increased with factors such as (i) duration of pregnancy caused by delay in the system or otherwise, (ii) illness in the patient, and (iii) lack of skill in the physician. In particular, the mortality rates in jurisdictions with elective abortion were lowest, primarily

because the patients were generally in good physical and mental "health." [58] In comparative samples from Hungary (1964-67), and Denmark (1961-65), the rates respectively were 1.2 and 41 deaths per 100,000 operations. Tietze, *supra* note 9, at 198, 208. Denmark, somewhat like Georgia, "require[s] the unanimous authorization of a committee of three persons, attached to the local Mothers' Aid, a publicly supported organization, which conducts a thorough medical and social investigation." *Id.* at 196. The added delay, in addition to the statutory limitations in Denmark, are responsible for the 41 less 1.2 deaths per 100,000. Rather than promoting public health, the Georgia statute is undoubtedly responsible for the death of a substantial number of women who endure the long waiting period for full certification, or who seek an abortion outside the clinical setting. A recent report on this precise problem stated:

> "Of the 205 nonhospital abortion deaths which occurred between 1950 and 1969, 143 or 69 per cent were of black women. Of the 25 women who died as a consequence of abortion in the last five years, 22 or 88 per cent were black." Rochat, *et al., An Epidemiological Analysis of Abortion in Georgia,* 61 AM. J. PUBLIC HEALTH 543 (1971).

Accordingly, it cannot be argued that this statute serves a public health interest. It appears to do quite the contrary, particularly in sanctioning medical abortion only in the cases wherein the patient already has some physical or mental health problem.

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[58] Inadvertent use of the terms "physical and/or mental health" in this brief is not intended to suggest that such terms would be intelligible in a criminal statute carrying severe sanctions. Declaratory expression and statutory proscription are altogether different word usages.

b. The provisions advance no legitimate interest in protecting human life

There is nothing in the legislative history of this statute which explains its purposes and how they relate to the individual provisions. On its face the statute does not purport to bestow value upon an embryo at every stage of development. Indeed, the same legal justifications for an induced abortion in the first week of pregnancy are also applicable at 20 weeks. Yet, at the outset of pregnancy, the fertilized ovum is scarcely visible to the eye, while at stages beyond 26 weeks, a possibility exists that the fetus could be sustained outside the woman's body.

The statutory provisions also do not seem predicated upon any assumption about the value of an embryo. For example, statutory rape (age 14) with consent which results in pregnancy is still a permissible justification for medical abortion, as is forcible rape. This condition, however, relates solely to events which affected the pregnant woman, not to any qualitative aspect of the embryo.

Similarly, the limitation of health justifications for legal abortion is difficult to explain or justify in terms of any principled rationale. Why, for example, must the patient be both *seriously and permanently* threatened in her health? What justification is there for excluding a woman who is only *seriously* threatened, or whose health would be *permanently* damaged, but not seriously? Certainly, the damage to the patient has no logical relation to the quality of the embryo, yet it is the criterion for the abortion.

c. The provisions do not advance any rational moral value

A last possible rationale which some might offer for the restrictions on induced abortion in this law is a moral one, *i.e.*, the deterrence of premarital or extra-marital sexual relations. Nothing in the statute, however, supports such a purpose. No distinction is made between the married and unmarried, even assuming that such a classification could otherwise withstand analysis. *See Eisenstadt* v. *Baird*, 429 F.2d 1398 (1st Cir. 1970), *prob. juris. noted*, 401 U.S. 934 (1971) (No. 70-17, 1971 Term).

No evidence exists that limited access to abortion curtails promiscuity, nor is it conceivable that such a correlation could exist. The widespread availability of contraception would seem to be a more significant factor. In any event, from the physician's standpoint, a patient is no less worthy of medical care simply because she has unfortunately conceived out of wedlock. Moreover, as one prominent physician observed, "[t]he fear that the availability of abortion will lead to promiscuity is sheer nonsense. . . ." Ryan, *Humane Abortion Laws and the Health Needs of Society*, 17 W. Res. L. Rev. 424, 432 (1965).

Decisions by this Court also indicate that such a justification for a statute must be more carefully tailored, and could be satisfied by enforcement of statutes outlawing adultery and fornication, if the State chose to do so. *See King* v. *Smith*, 392 U.S. 309, 320 (1968); *Griswold* v. *Connecticut*, 381 U.S. 479, 498 (1965) (Goldberg, J., concurring).

2. The requirement that patients requesting a therapeutic or elective abortion be examined and certified by three physicians, and that certifications be approved further by a hospital committee of three or more physicians, is neither narrowly drawn nor supportive of a compelling state interest

In regard to no other medical procedure does Georgia law require that a patient's case be evaluated or approved by anyone other than her chosen physician. In medicine, as in law, the right to the physician of one's choice, and to privacy in the physician-patient relationship, has not been invaded by state legislation, except in this single area. Not only do the triple examination provision and committee certification procedure impose a burden upon physicians and patients from a policy standpoint, but there appears to be no rational basis whatever for such procedures, other than the impermissible reason of curtailing access to health care.

Three features of the multiple consultation-examination-certification process are unsupportable.

a. The consulting requirement precludes a clinical relationship by creating an adversarial one, which serves no medical purpose

By the time a patient requests aid from her physician in obtaining a medical abortion, she has generally made the decision to go forward unless some overwhelming physical or psychic hazard dictates otherwise. As seen previously, no such hazards exist, particularly in the case of healthy women.

It is an elementary medical proposition that proper treatment requires a relationship of confidence and trust between doctor and patient. The proposition applies more

forcefully when examination and treatment are psychiatric in nature. Where the statute requires written approval by consulting physicians regarding prescribed indications, however, the trust relationship is impossible:

> "[A] word should be said about the conditions for making a valid psychiatric evaluation of a woman who presents herself in a state of acute anxiety attendant upon being pregnant, and is determined to find ways and means of aborting. This is a most prejudicial situation for a psychiatric interview, because under such circumstances optimal cooperation from the patient is not obtainable. She has a tendentious purpose which she must pursue; therefore, it is difficult for her to be candid. The psychiatric interview is compromised from the outset. . . . To conduct such an interview with a patient who is committed to the ulterior motive of obtaining consent for an abortion is to do so against odds; too much must be left to the opinion and value judgment of the psychiatrist." Aarons, *Therapeutic Abortion and the Psychiatrist,* 124 AM. J. PSYCHIATRY 745, 747 (1967).

The state interference with a normal physician-patient relationship is complicated by the statute's listing of legal justifications for a medical procedure. The patient knows this fact, and that she must persuade a line of physicians that she "fits" into the classifications. Advocacy, rather than treatment, is her goal. Rather than imposing trust in her private physician, she realizes that two additional examining physicians and an anonymous hospital committee must also be persuaded, and that the latter will not even see or examine her overall problem. The first defect

in the procedure, therefore, is its destruction of the physician-patient relationship. Without the multiple physician procedure, the patient would be more willing to reveal her overall problem, and to request whatever collateral treatment and counseling might be needed in connection with the abortion procedure.

b. Multiple physician consultations have no rational justification where the patient has no specialized medical problem which could complicate the induced abortion procedure

In medicine, as in law, a generalist calls in specialist consultation when the patient (or client) has a specialized problem. For example, without abortion-specific statutes, a gynecologist would have no need to seek consultation unless non-gynecological problems might complicate the procedure. In a case of a potentially complicating heart condition, a gynecologist might call in a cardiologist. For a patient with a kidney condition, the gynecologist might call in an expert on the renal function. For the patient with serious mental problems, a psychiatrist might be called in. Rarely would more than one specialist be called upon. As the medical literature shows, such consultations simply serve no medical purpose. For this reason, the policy statement of the ACOG recommends the following:

> "When abortion is requested by a patient, a consultation is not necessary. When abortion is recommended by a physician, the indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion." APPENDIX A, *infra*, at A-1.

ACOG does not recommend more than one consultation, and that in the limited circumstance of a recommended abortion. Clearly, no multiple examination and certification procedure can be justified, and none is recommended.

Medical texts, and recent studies of abortion law implementation, have pointed out the lack of medical necessity for consultation, and in strong unequivocal language. The text co-authored by *Amicus* J. Robert Willson, immediate past-president of ACOG, for example, states:

> "When abortion becomes legal in all states there will be no need for 'therapeutic abortion committees' or even for consultation except under unusual circumstances." J. R. WILLSON, *et al.*, OBSTETRICS AND GYNECOLOGY 178 (4th ed. 1971).

Dr. Edmund Overstreet, recently retired chairman of obstetrics and gynecology at the University of California, San Francisco, Medical Center, and also an *Amicus*, agrees, and has recommended:

> "Determination by the patient's physician alone (private or resident) of the validity of the patient's desire for termination of pregnancy—with resort to consultations only when he is in doubt.
>
> "The Hospital Therapeutic Abortion Committee should be abolished. Current practice shows it to be essentially worthless, almost purely pro forma in operation, an enormous waste of physician time, and a hindrance to prompt, effective abortion practice." Overstreet, in *Symposium—Pregnancy Termination: The Impact of New Laws*, 6 J. REPRODUCTIVE MEDICINE 274, 285 (June 1971).

In sum, the hospital certification and multiple physician consultation procedures should be recognized for what they are and always have been: devices designed to reduce the numbers of abortions in a hospital, and to avoid possible criminal and administrative sanctions against the institution. There is no evidence that they serve any other function.

c. The committee process is devoid of procedures which remotely resemble those required by the due process clause

Not only is the multiple physician approval system unwarranted by medical or psychiatric considerations, but there is no procedure whereby the physicians' and patients' fundamental claims can be evaluated in an orderly fashion. As previously shown in this brief, the interests asserted by both physician and patient are fundamental and of significant constitutional stature. Yet neither has an opportunity to be heard before the hospital abortion committee, nor any other administrative agency. Indeed, under the law in question, there is no requirement that a hospital even set up such a committee.

A hearing requirement would not eliminate the more fundamental objections to the statutory restrictions, but at least it would permit physician and patient to present facts and argument in support of the application for a therapeutic abortion. Moreover, procedural due process would require that hospital committees articulate more definitive policies than those in the statute, and that reasoned justification be given for the rejection of any patient's application.

The procedural due process decisions by this Court, from *Baldwin* v. *Hale,* 68 U.S. (1 Wall.) 223 (1864), to *Goldberg*

v. *Kelly*, 397 U.S. 254 (1970), and *Boddie* v. *Connecticut*, 401 U.S. 371 (1971), require that the statutory provisions for additional examining physicians, and hospital committee approval, be stricken as contrary to the Fourteenth Amendment due process clause.

The Georgia therapeutic abortion act imposes state control over all medical procedures directed toward interruption of pregnancy. Administration of this act is vested in hospital governing boards, therapeutic abortion committees, and miscellaneous additional consulting physicians. The act establishes "the State's monopoly," over decisions which bear in an important way upon physicians, women, and their families. *See Boddie* v. *Connecticut*, 401 U.S. 371, 375 (1971). Under such circumstances, resort to hospital committees and consultation with additional examining physicians "is no more voluntary in a realistic sense than that of the defendant called upon to defend his interests in court." *Boddie, supra*, at 376-77. As Mr. Justice Harlan stated for the Court in *Boddie*:

> "Prior cases establish, first, that due process requires, at a minimum, that absent a countervailing state interest of overriding significance, persons forced to settle their claims of right and duty through the [administrative] process must be given a meaningful opportunity to be heard." *Id.* at 377.

Procedural due process hearings have been held necessary under the due process clause before professional disciplinary sanctions could be imposed, *In re Ruffalo*, 390 U.S. 544 (1968), before public assistance could be terminated, *Goldberg* v. *Kelly*, 397 U.S. 254 (1970), and before wages could be garnished, *Sniadach* v. *Family Finance Corp.*, 395 U.S. 337 (1969). *See also Greene* v. *McElroy*, 360 U.S.

474 (1959). Where, as here, the fundamental right of access to health care is at stake, and a particular form of medical care has been singled out, an administrative system which denies any hearing whatever cannot withstand scrutiny under the concepts of due process enunciated by this Court. *Cf. Baxtrom* v. *Herold,* 383 U.S. 107 (1966).

3. The requirement that the medical procedure of abortion be undertaken only in hospitals accredited by the Joint Commission on Accreditation of Hospitals unjustifiably discriminates against a single medical procedure, and seriously limits the availability of medical facilities for abortion, without advancing any compelling state interest

Nothing in the Model Penal Code draft abortion law suggested that all medical abortions be performed in those hospitals accredited by the Joint Commission on Accreditation of Hospitals [JCAH]. The Code, which was innovative when the 1955 first draft was circulated,[59] made the following recommendation with respect to the type of facility:

> "Hospital facilities are overburdened, and in some rural areas inaccessible. It may be assumed that hospitals maintained by some religious groups would not permit abortion under any circumstances. The operation is ordinarily not difficult or dangerous when performed by a competent physician, so that medical considerations alone do not call for hospitalization. Accordingly, Subsection 2(b) leaves it open to the state. . . ."

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[59] More recently, in 1970, the second tentative draft of the UNIFORM ABORTION ACT (Aug. 1970), stipulated that the procedure could be performed "in a medical clinic, or in a hospital . . . ."

MODEL PENAL CODE §207.11, Comments, at 157 (Tent. Draft No. 9, 1959).

Eight of the twelve A.L.I. states[60] failed to heed the Code's recommendation, and went even further by requiring that all medical abortions be undertaken in JCAH-accredited facilities. This excluded licensed hospitals which had not sought accreditation, as well as specialized hospital-affiliated medical facilities designed for the abortion procedure and other family planning medical care.

As a preliminary matter, it is necessary to identify the JCAH, its nature, history, and standards, as well as the purpose behind those standards.

The JCAH is not a unit of Georgia government, nor indeed of any governmental unit in the United States. It is a private, nonprofit corporation, with headquarters in Chicago, and is not even within the jurisdiction of any states with accreditation requirements, much less subject to their control.[61]

JCAH was an outgrowth from the Hospital Standardization Program established by the American College of Surgeons in 1918 for the purpose of encouraging uniform medical records. *Accreditation Manual for Hospitals* 1 (JCAH 1970). *See generally* L. E. DAVIS, FELLOWSHIP OF SURGEONS: A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS (1960). In 1951 JCAH came into existence to

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[60] Georgia, Virginia, California, Colorado, Delaware, Kansas, Maryland, and Arkansas.

[61] JCAH is located at 645 North Michigan Avenue, Chicago, Illinois 60611. Publications of the Commission are available to the general public, and are contained in most medical libraries.

broaden the aforesaid program, and to promulgate standards for voluntary evaluation of "community general hospitals. . . ." *Statement by John I. Brewer, M.D., Commissioner, JCAH* (July 9, 1971), APPENDIX A, *infra,* at A-2.

Seven different versions of *JCAH Standards* have been promulgated since the original December 1953 version, including the more recent which came into effect during the pendency of this litigation. These seven were in January 1956, October 1957, December 1960, January 1964, December 1965, and July 1971. The most recent is a massive, thoroughly revised 152 page document, as contrasted with the previous 10 page standards from 1965.

In at least three respects, the incorporation into Georgia law of the JCAH standards cannot be reconciled with the requirements of the Equal Protection clause.

a. The JCAH itself does not advocate that medical procedures be confined to a given type of facility or limited to particular patient circumstances

The very purpose behind legislative incorporation of JCAH standards has been misconceived from the outset. As shown by the JCAH standards themselves, and the statement of JCAH Commissioner Brewer, "[t]he principal function of the Joint Commission . . . is to develop standards of quality for *community general hospitals* . . . ." (emphasis added) *Id.* [hereinafter Brewer Statement]. JCAH is simply not involved in accrediting special purpose institutions at the present time, except for "long term care facilities (such as nursing homes) and for rehabilitation facilities." *Id.* At some future date, JCAH may well set up a program for this purpose, but the Commission does not now pretend to approve or disapprove specialized family planning facilities.

Ironically, if JCAH were to establish a specialty program in the near future, a JCAH-accredited family planning facility, affiliated with or accessible to a hospital, still could not offer the medical procedure of induced abortion in Georgia. Such a facility would have the JCAH stamp of approval as a specialized facility, but not as "a hospital . . . accredited by the" JCAH. GA. CRIM. CODE §26-1202(b)(4) (1969).

Not only does JCAH expressly disavow application of its standards to specialized medical facilities, but JCAH also has no policies and no procedures with respect to any particular medical treatment. JCAH is concerned with the physical plant and general administrative operation of community hospitals, not with non-hospital medical facilities, nor with the specifics of any given medical treatment. As stated by Commissioner Brewer,

> "The Joint Commission does not now have and has never had a policy or a standard which attempts to limit medical practice or any of its individual components to the confines of an accredited hospital, nor indeed to any specific location." Brewer Statement.

Similarly, with respect to medical practice in a given sphere,

> "The [JCAH] standards do not attempt to establish any indication of the content of medical practice, but rather refrain from imposing any specific national criteria of quality of that nature. . . . The Joint Commission neither advocates nor opposes any particular position with respect to elective abortions." *Id.*

In light of the JCAH position, the limitation of medical abortions in Georgia to JCAH-accredited facilities cannot be sustained. It is not "based on differences that are reasonably related to the purposes of the [standards incorporated in] the Act in which it is found." *Morey* v. *Doud*, 354 U.S. 457, 465 (1957).

Similarly, the provision in GA. CRIM. CODE §26-1202(b)(5) (1969), requiring that hospital therapeutic abortion committees be "established and maintained in accordance with the standards promulgated by the [JCAH] . . . ," is meaningless. The JCAH has no such standards for these committees, and never has. One can search the JCAH Standards and Bulletins in vain for any guidance. The nearest item is an August, 1966 Bulletin, since replaced by the 1971 revision,[63] which recommended consultation in cases of interruption of pregnancy, in particular because of laws "identifying the conditions, if any, under which the procedures may be undertaken." [64] As to "standards promulgated by the [JCAH] . . . " GA. CRIM. CODE §26-1202(b)(5) (1969), the JCAH referred this back to the medical facility:

> "The Joint Commission has no ruling making such [therapeutic abortion approval] committees mandatory. It is expected that each hospital medical staff will include in its by-laws the controls which it considers appropriate for that hospital's practice." [65]

Whatever the result of this circular shifting of responsibility may be, it is clear that with respect to hospital abortion committees, there are no JCAH standards.[66]

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[63] Bulletin No. 42, JCAH (Aug. 1966).

[64] *Id.*

[65] *Id.*

[66] In light of this consideration, it is unnecessary to resolve the further problem presented by the fact that JCAH standards change

b. No public health justification can be advanced for confining the medical procedure of abortion to those limited institutions which are JCAH-accredited

What has been found concerning the irrelevance and express inapplicability of JCAH standards to specialized medical facilities and procedures should be sufficient to conclude the argument that the GA. CRIM. CODE §26-1202(b)(4)-(5) (1969), provisions violate the Due Process and Equal Protection clauses of the Fourteenth Amendment. In addition, however, *Amici* would like to point out other defects in the statutory limitation of medical abortions to JCAH-accredited facilities.

Earlier in this brief, *Amici* established beyond dispute the comparative safety of induced abortion as contrasted with other medical procedures. *See* pp. 10-13, *supra*. If the statutory purpose of confining medical abortions to JCAH hospitals is an interest in patient welfare, the interest is misplaced. Not only may all forms of heart surgery be done in non-accredited facilities, but the same medical procedure performed to interrupt a pregnancy may be done in any other medical facility when there is no suspected pregnancy. Indeed, every medical procedure except induced abortion can lawfully be undertaken in any medical facility selected by the physician and patient, regardless of surgical complexity. It is not even a crime in Georgia

---

from time to time, in a manner entirely beyond the regulatory power of Georgia or other A.L.I. jurisdictions.

In addition, it is not necessary to deal with the fact that Georgia and the other A.L.I. states attempted to delegate regulatory powers to a private corporation outside their jurisdiction, without providing any guidelines for exercise of the regulatory authority. *Compare* Shuttlesworth v. City of Birmingham, 394 U.S. 147 (1969).

for major surgery to be undertaken in altogether unlicensed and inadequate facilities.

In light of the comparative safety factor, there is no rational basis for setting induced abortion apart from all other medical procedures.

If, however, one assumes *arguendo* a valid legislative purpose in prohibiting the medical procedure of abortion, except in approved facilities, the limitation to fully accredited general community hospitals is still medically unjustifiable. Not only do data from specialized medical facilities for abortion show acceptable safety, but medical science may be only a matter of years away from the development of abortion-inducing drugs which surely need not be swallowed within a JCAH-accredited general community hospital.

A study based on experience under California's A.L.I.-type statute at the University of California Medical Center, San Francisco, sought to identify complications from abortion procedures and the extent of necessity for full hospitalization. *See* Margolis & Overstreet, *Legal Abortion Without Hospitalization*, 36 OBSTETRICS & GYNECOLOGY 479 (1970). The physicians found that "none of [the] post-abortal complications—all of which were handled with minimal therapy—developed earlier than 2 days after the abortion, and most occurred from 3 to 30 days after the procedure." *Id.* at 480-481. They concluded that "the conventional 12- to 48-hour hospital admission for aspiration abortion patients serves no real purpose either in preventing or discovering post-abortal complications." *Id.* at 481.[47]

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[47] Similar experience has been recorded in England. *See* Huntingford, *Mortality and Morbidity of Abortion*, THE LANCET, at 1012 (May 15, 1971):

A more recent study at the same California institution confirmed and strengthened the earlier conclusions. *See* Goldsmith & Margolis, *Aspiration Abortion Without Cervical Dilation,* 110 Am. J. Obstetrics & Gynecology 580 (1971). Using a newly developed technique which reduced the need for anesthetic and cervical dilation, the reporting physicians concluded:

> "With well-qualified personnel who are careful to accept only pregnancies early in the first trimester, and who perform the aspiration technique skillfully, out-of-hospital abortion in well-equipped, licensed facilities seems feasible." *Id.* at 582.

Similar experience was recorded by the Medical Director of Planned Parenthood of Syracuse, in a study of 600 cases of early induced abortion. Penfield, *Abortion Under Paracervical Block,* 71 N. Y. State J. of Medicine 1185 (1971). Dr. Penfield's scholarly analysis, which included a systematic review of much overlooked literature in the field, concluded:

> "A review of the world literature has demonstrated that dilatation and curettage [the early abortion operative procedure] under paracervical block [local anesthesia] is a safe and usually painless procedure.
>
> "The author's series of more than 600 first-trimester surgical abortions has also shown the acceptability of this technic when performed in a well equipped outpatient or office facility." *Id.* at 1189.

"The evidence available does not show that prolonging the duration of stay of women in hospital after abortion prevents complications, although it may serve to increase the detection-rate. But the detection-rate could also be increased by an adequate system of follow-up. . . ."

Comparable observations can be traced back to as early as 1925, and a paper by the famed Howard A. Kelly, M.D., of Johns Hopkins, on non-hospital uterine curettage, 9 Am. J. Obstetrics & Gynecology 78 (1925). *See also* Israel & Mazer, *Safety and Advantage of Office Curettage,* 36 Am. J. Obstetrics & Gynecology 445 (1938).

In addition, current research is underway in numerous American medical centers, as well as abroad, to perfect a safe, reliable abortifacient in tablet form. *See* Anderson & Speroff, *Prostaglandins,* 171 Science 502 (1971); Speroff & Ramwell, *Prostaglandins in Reproductive Physiology,* 107 Am. J. Obstetrics & Gynecology 1111 (1970). When developed, however, such a substance would still be unlawful in Georgia unless taken in a JCAH-accredited hospital after the full range of consultant physician approvals and committee certification. This possibility, which may become reality in a very few years, perhaps best illustrates the unjustifiable nature of the legislation under review in this case.

The logic of the most recent findings set out above goes far beyond the position necessary to invalidate the JCAH-accreditation requirement. *Amici,* however, take no position beyond that necessary to support Appellants' constitutional objections to the JCAH rule. Admittedly, the medical procedure of induced abortion, late in the pregnancy of an unhealthy patient, performed in an inferior facility by an incompetent operator, is a dangerous procedure. Administrative regulations may be thought necessary to establish specific standards of care directly related to this or any other medical procedure. The statute in question, however, is not a finely tailored administrative regulation,

but a blunt prohibition. It contravenes the principle so often enunciated by this Court that

> "[l]egitimate legislative goals 'cannot be pursued by means that broadly stifle fundamental personal liberties when the end can be more narrowly achieved.'" *Elfbrandt* v. *Russell*, 384 U.S. 11, 18 (1966).

By contrast, the States of Washington and New York, through health department regulations, have promulgated guidelines for medical facilities outside of the JCAH-accredited institution. *Abortion Regulations Adopted by the Washington State Board of Health* (Dec. 10, 1970); *Abortion Services*, N.Y.C. HEALTH CODE tit. III, art. 42, 98 CITY RECORD 6313-6315 (Oct. 23, 1970). These illustrate the concept of carefully drawn health regulations for specialized facilities.[68] Reproductions are included in the offset Supplementary Appendix to this brief. SUPPLEMENTARY APPENDIX, at 15, 11.

In sum, the lower court passed lightly over the Appellants' objections to the JCAH-accreditation requirement. A deeper analysis was necessary to a meaningful adjudication. *Amici* have attempted to provide this Court with the materials and arguments necessary to a full evaluation of this question, and have reached a conclusion in accord with the better reasoned precedent in point. *See People*

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[68] A study of the Hawaii abortion law, which initially required hospitalization, has concluded with the recommendation that:

> "It is possible to perform safe, efficient abortions on an outpatient basis on women pregnant less than twelve weeks. Clinics set up to do this would probably result in significantly lower individual patient costs." R. Smith, *et al.*, *Report to the Legislature: State of Hawaii—Hawaii's Abortion Law* 15 (Apr. 20, 1971).

See also Recommended Standards for Abortion Services (APHA 1970).

v. *Barksdale*, —— Cal. App. 3d ——, —— Cal. Rptr. ——, 1 Crim. 9526 (Calif. Dist. Ct. App. July 22, 1971).

4. The Prohibition Further Limiting Access to the Medical Procedure of Induced Abortion to the Single Class of Patients Who Are "Bona Fide Legal Resident[s] of the State of Georgia" Violates the Privileges and Immunities Clause of Article IV, §2, and the Equal Protection Clause of the Fourteenth Amendment by Excluding Non-resident Patients for Reasons Which Are Neither Narrowly Drawn Nor Supportive of Any Legitimate, Compelling State Interest

The final unconstitutional provision of the Georgia abortion law limits this medical procedure to "bona fide legal resident[s] of the State of Georgia." GA. CRIM. CODE §26-1202(b)(1)-(2) (1969). Without discussion, the lower court upheld the requirement. *Doe* v. *Bolton*, 319 F. Supp. 1048, 1056 (N.D. Ga. 1970) (per curiam). A contrary view was taken by a three-judge federal district court in North Carolina, with respect to a four month durational residency requirement. *Corkey* v. *Edwards*, 322 F. Supp. 1248, 1254 (W.D.N.C.), *appeal docketed*, 40 U.S.L.W. 3048 (U.S. July 17, 1971) (No. 71-92, 1971 Term).

From the medical standpoint, a patient's needs are not less deserving of care by virtue of his or her residence in any particular city or town. The history of medicine is replete with instances of great medical centers frequented by prominent citizens from other states and nations. Presidents and Justices of this Court have travelled to the Mayo Clinic for decades. *See* H. CLAPESATTLE, THE DOCTORS MAYO (1941). If the Georgia residency require-

ment is valid, a like provision limiting medical care in general to state residents would be equally valid.

It requires little analysis, and less data, to demonstrate the arbitrary nature of the residency requirement in this and similar statutes. The requirement of residency is not limited to those patients seeking free medical care at public institutions, in which case different considerations would be involved. Instead, the private patient of a private physician in a private medical facility must present a passport of Georgia state residency in order to be considered as an applicant for the medical procedure of induced abortion. Both she and the physician must certify to her residency under oath.

The provision has no basis in the possibility that Georgia hospital beds will otherwise be utilized beyond capacity. According to the annual report of the American Hospital Association, the 29,872 beds in the State's 153 non-federal hospitals were in use during 1969 only 80.8% of the time. *Hospitals* (pt. 2), 44 J. Am. Hospital Ass'n 1, 483, Table 3 (1970) (Guide Issue). As previously pointed out, 96% of Georgia's counties had fewer than 10 legal abortions in 1970. Indeed, more Georgia residents obtained legal abortions in New York City from July 1, 1970 to March 31, 1971 than in their State of residence. It is New York, if any state, which has standing to complain of an influx of abortion applicants. Yet, all New York officials agree that both the State and a large part of the nation have been accommodated without sacrificing the quality of medical care. *See* Chase, *Abortions to Out-of-State Residents* (June 29, 1971) (Report released by the Health Services Administration, City of New York).

Two traditional constitutional bases can be invoked to invalidate the residency provision.

Article IV, §2 of the Constitution guarantees that "[t]he Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States."

A classical exposition of the purpose of the clause is Justice Washington's opinion in *Corfield* v. *Coryell,* 6 Fed. Cas. 546, 550 (C.C.E.D. Pa., 1832) (No. 3,230):

> "The inquiry is, what are the privileges and immunities of citizens in the several states? We feel no hesitation in confining these to those privileges and immunities which are, in their nature, fundamental; which belong, of right, to the citizens of all free governments; and which have at all times been enjoyed by the citizens of the several states which compose this Union, from the time of their becoming free, independent, and sovereign. What these fundamental principles are, it would perhaps be more tedious than difficult to enumerate. They may, however, be comprehended under the following general heads: Protection by the government; the enjoyment of life and liberty, the right to acquire property of every kind, and to pursue and obtain happiness and *safety,* subject, nevertheless, to such restraints as the government may justly prescribe for the general good of the whole" (emphasis added).

Since that early interpretation, this Court has repeatedly upheld the citizen's right to enter another state for the purpose of engaging in lawful commerce, trade, or business; to acquire personal property; to take and hold real estate; to maintain actions; and to be exempt from any higher taxes or excises than are imposed upon its own citizens. *See, e.g., Paul* v. *Virginia,* 75 U.S. (8 Wall.) 168,

180 (1869); *Ward* v. *Maryland,* 79 U.S. 418, 430 (1870); *Blake* v. *McClung,* 172 U.S. 239, 248-254 (1898); *Toomer* v. *Witsell,* 334 U.S. 385, 395-397 (1948). In *Blake,* a Tennessee statute afforded resident creditors a preference over non-residents in the distribution of assets of insolvent foreign corporations with property in the state. In an action by Tennessee creditors seeking distribution of assets of an insolvent foreign corporation, non-resident creditors who were citizens of other states intervened and resisted the priority given the resident creditors. The Court held the statute to infringe the rights of the intervenors:

> "It was the right of citizens of Tennessee to deal with it [a foreign corporation], as it was their right to deal with corporations created by Tennessee. And it was equally the right of citizens of other states to deal with that corporation. . . . But the enjoyment of these rights is materially obstructed by the statute in question, for that statute, by its necessary operation, excludes citizens of other states from transacting business with that corporation upon terms of equality with citizens of Tennessee." 172 U.S. at 252-253.

Similarly, *Ward* v. *Maryland, supra,* struck down a Maryland law which imposed a licensing fee on non-residents for selling goods not produced within the state in certain areas. The Court held that the statute imposed on other states' citizens a discriminatory tax which infringed their rights to trade on equal terms with Maryland citizens.

The *Blake* and *Ward* cases both concerned state citizens who entered other states in order to ply their trade. No less deserving constitutional protections, however, are state citizens who enter other states in order to partake of an-

other's business. This was recognized in *Valle* v. *Stengel*, 176 F.2d 697 (3d Cir. 1949), which held, alternatively, that New York citizens' rights under the Privileges and Immunities clause were infringed when they were denied access to a swimming pool operated by a private corporation, but open to the public upon payment of a fee.

Here, the residence requirement precludes citizens of other states from seeking particular medical treatment in Georgia, whereas Georgia citizens are not so constrained. Citizens and residents of Florida, Alabama, Tennessee, North Carolina and South Carolina who live near the Georgia border are prohibited from receiving medical care for abortion even if their regular gynecologists are Georgia doctors. Citizens from other states who visit Georgia cannot be aborted even in the most compelling medical emergencies. The statute may not only infringe rights to engage professional services on equal terms with Georgia residents, but may cause severe injury as well.

In order to avoid invalidation under Article IV, §2, a discriminatory statute must be based on a substantial independent justification. The Court in *Toomer* v. *Witsell*, 334 U.S. 385 (1948), stated this test:

> "... [T]he privileges and immunities clause is not an absolute. It does bar discrimination against citizens of other States where there is no substantial reason for the discrimination beyond the mere fact that they are citizens of other States. But it does not preclude disparity of treatment in the many situations where they are perfectly valid independent reasons for it. Thus the inquiry in each case must be concerned with

whether such do exist and whether the degree of discrimination bears a close relation to them" 334 U.S. at 396.

No substantial reason exists for Georgia to prohibit non-resident women from seeking medical services there to terminate pregnancies. A desire to conserve medical resources for the exclusive use of residents cannot justify the residence requirement; medical resources often are private and are not "common property" of the State. *Cf. McCready* v. *Virginia,* 94 U.S. 391 (1877), as limited by *Toomer* v. *Witsell,* 334 U.S. 385 (1948), and *Mullaney* v. *Anderson,* 342 U.S. 415 (1952). At the same time, any such conservation policy is invidiously underinclusive: non-residents are prohibited from seeking medical services only if they seek to terminate pregnancy through abortion. Neither can a desire to conserve state funds for the use of state residents justify this section, for it applies equally to private and public hospitals, physicians, and patients. *Cf. American Commuters Ass'n* v. *Levitt,* 279 F. Supp. 40 (S.D.N.Y. 1967). Without a substantial justification, the residence requirement violates Article IV, §2.

For substantially the same reasons, the residency requirement cannot withstand analysis under the Equal Protection clause of the Fourteenth Amendment. In this context, Article IV, §2, and the Equal Protection clause run together. *See Graham* v. *Richardson,* 402 U.S. —— (June 14, 1971); *Shapiro* v. *Thompson,* 394 U.S. 618, 638 (1969).

CONCLUSIONS

For the reasons set forth, this Court should modify the judgment below by affirming the District Court's decision that certain portions of Georgia Criminal Code §26-1202 violate Appellants' federal constitutional rights, reversing the decision below to the extent that other portions were held valid, and reversing the decision to deny injunctive and declaratory relief to the class of physician appellants.

Respectfully submitted,

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CONCLUSIONS

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APPENDIX A

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The American College of Obstetricians and Gynecologists Policy Statement A-1

Statement by John I. Brewer, M.D., Commissioner, Joint Commission on Accreditation of Hospitals, July 9, 1971 ..... A-2

A-1

THE AMERICAN COLLEGE
OF OBSTETRICIANS AND GYNECOLOGISTS
79 West Monroe Street • Chicago, Illinois 60603
Telephone 312-236-6814

POLICY ON ABORTION

Policies covering abortions should be designed by the medical staff to safeguard the patient's health or improve her family life situation. They should have due regard for local legal statutes and judicial decrees. Abortion should only be performed in facilities that are administered by a hospital approved by the Joint Commission on Accreditation of Hospitals and/or licensed by a state or province.

It is recognized that abortion may be performed at a patient's request, or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept an abortion.

When abortion is requested by a patient, the request should be obtained in writing from the patient, or, in the case of a minor, from her parent or guardian. The patient should be informed of the medical nature of the procedure and of its potential consequences. When abortion is recommended by a physician, the indications should be stated in the patient's record, and informed consent obtained from the patient and her husband, or herself if she is unmarried, or from her nearest relative or guardian if she is under the age of consent. When abortion is requested by a patient, a consultation is not necessary. When abortion is recommended by a physician, the indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion.

Abortion is an operative procedure and should only be performed: (1) by a physician who has hospital privileges for the care of obstetric-gynecologic patients and (2) in a hospital-facility adequately equipped to care properly for unexpected complications.

In order to assure that adequate facilities will be available for indicated care of other obstetric-gynecologic patients in some communities, consideration should be given by hospitals to (1) providing a room or entirely separate facilities where abortion can be performed with minimal disruption of other hospital procedures and the hospital based educational program, and (2) utilizing hospital personnel who volunteer to care for patients admitted to be aborted.

Approved by the Executive Board
August 1970

NINETEENTH ANNUAL CLINICAL MEETING
Civic Auditorium, San Francisco, California, May 3-6, 1971

A-2

Statement by John I. Brewer, M.D., Commissioner,
Joint Commission on Accreditation of Hospitals
July 9, 1971

Joint Commission on Accreditation of Hospitals
645 North Michigan Avenue Chicago, Illinois 60611

July 9, 1971

JOHN D. PORTERFIELD, M.D.
Director (312) 642-6061

	AB	7/13		

Allan C. Barnes, M.D.
Vice President
The Rockefeller Foundation
111 West 50th Street
New York, New York 10020

Dear Doctor Barnes:

It has come to my attention that the origin, background and purposes of the Joint Commission on Accreditation of Hospitals should be more widely and more accurately known. This is particularly true where the actions of the Joint Commission are a factor in judicial considerations. I should like to submit therefore a brief account of the Joint Commission and its purposes.

The Joint Commission on Accreditation of Hospitals was incorporated in late 1951 as a voluntary corporation not for profit. Its corporate members are the American College of Physicians, the American College of Surgeons, the American Hospital Association and the American Medical Association. It was created to continue a program begun by the American College of Surgeons in 1918, the Hospital Standardization Program.

The principal function of the Joint Commission, as was true of its predecessor program, is to develop standards of quality for community general hospitals, to promulgate these standards among health professionals, on invitation to evaluate the condition and procedures of hospitals, and to recognize substantial conformance to its standards by granting a certificate of accreditation. Evaluation is made in a survey visit, requested by the hospital, which must be repeated at least biennially. The survey visit is carried out by a professional team, headed by a physician trained in accreditation methods.

Present hospital accreditation standards were adopted by the Joint Commission Board of Commissioners in 1970. In their formulation extensive use was made of outside expert advisors, some 250 in all. Before adoption, the standards were also submitted to formal and informal review by substantial numbers of interested individuals and organizations.

The standards address themselves to the safety and maintenance of the physical plant of the hospital; to the organization and functioning of the hospital's governing authority and its medical staff; to the provision of adequate and efficient space, equipment and personnel for the necessary diagnostic and therapeutic resources; and to the continuing exercise of appropriate controls to assure effective performance, among which most particularly shall be a regular, critical review by the medical staff of the calibre of clinical work being done by each of its members.

A-3

The standards do not attempt to establish any indication of the content of medical practice, but rather refrain from imposing any specific national criteria of quality of that nature. Instead the organized medical staff of each hospital seeking voluntary accreditation is expected to define, in its bylaws, rules and regulations, those clinical policies which identify the essential factors of good medical practice. The Joint Commission neither advocates nor opposes any particular position with respect to elective abortions. Each physician's practice must be measured by his hospital's medical staff against the clinical policies adopted in that hospital.

While the standards are written for and the program is directed primarily toward community general hospitals, many special hospitals - such as psychiatric, orthopedic, pediatric and others - have sought, and frequently have obtained, accreditation within this program, in lack of a comparable program for the particular specialty. A criterion for eligibility for accreditation survey is registration as a hospital with the American Hospital Association. The Joint Commission does not therefore offer accreditation to clinics or group practice situations as such.

Recently, the Joint Commission has agreed to an organization relationship with groups of national associations wishing to develop special accreditation programs in fields of health-related services. Presently, by this arrangement, accreditation programs are available for long term care facilities (such as nursing homes) and for rehabilitation facilities. Standards are currently being developed by other associated groups for psychiatric facilities and for facilities for the mentally retarded.

The Joint Commission does not now have and has never had a policy or a standard which attempts to limit medical practice or any of its individual components to the confines of an accredited hospital, nor indeed to any specific location. It concerns itself only with the institutional setting of medical practice and does not presume to concern itself with medical practice in any setting outside the purview of its formally organized programs.

A much more detailed description of the work of the Joint Commission is available upon request to its office at 645 North Michigan Avenue, Chicago, Illinois 60611.

Sincerely,

John I. Brewer, M.D.
Commissioner
Joint Commission on Accreditation of Hospitals

Professor
Department of Obstetrics and Gynecology
Northwestern University Medical School

JIB:sp

STATE OF ILLINOIS
COUNTY OF COOK

Subscribed and sworn to before
me this 12th day of July, 1971.

Patricia A. Carnell
Notary Public
Commission expires April 24, 1973.

APPENDIX B

APPENDIX B

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EXPLANATORY NOTES

SECTION I. This Section contains information in summary form on therapeutic abortion in the United States. In particular, it focuses on the implementation in ten states of the therapeutic abortion provisions of the American Law Institute's Model Penal Code as enacted in varying forms. Little data could be obtained from the two other states, Arkansas and Kansas, which have adopted this type of statute.

SECTION II. This Section consists of state summaries in table and map form on trends in therapeutic abortion in the ten A.L.I. states for which data was available. The data in Table II is presented in a manner that draws distinctions between metropolitan and non-metropolitan areas. This format, it was thought, most clearly demarcates the trends in the implementation of the therapeutic abortion statutes.

A "metropolitan county" as it is used herein is one which is located within Standard Metropolitan Statistical Area (SMSA) as calculated in Bureau of the Census, 1960 Census of the Population, Vol. 1, Ch. A.

SECTION III. The final Section consists of tables presenting the actual distribution of therapeutic abortions by county and hospital of occurence for the A.L.I. states. The data is by county only for Georgia, Virginia, Oregon and California where a hospital by hospital breakdown was not available.

1. "TA Ratio" is the therapeutic abortion ratio, the number of therapeutic abortions per 1000 live births. It is the standard measure of abortion frequency. *E.g.*, the ratio of 15 therapeutic abortions to 50 live births is 300.

2. Statistics on therapeutic abortion, including frequencies, places of occurrence, and indications, were obtained from the appropriate state agencies, *infra*. The source for the numbers of births for each year was *Guide Issue*- Journal of the American Hospital Association (August, 1968, 1969, 1970). Because the 1971 issue, which contains the 1970 births, was not available when the tables were being prepared, the 1970 issue was used for the 1969 and 1970 statistics.

State sources for therapeutic abortion data:
Georgia: Department of Public Health (unpublished material).
South Carolina: State Board of Health (personal communication from Dr. J.E. Padgett, Jr., Chief, Bureau of Maternal and Child Care). (Time period for therapeutic abortion is February, 1970 to May, 1971; births have been adjusted accordingly).
North Carolina: State Office of Vital Statistics (unpublished material, January 28, 1971). (Represents 75% of all therapeutic abortions performed in North Carolina to that date. J. May, *Therapeutic Abortion Experience in North Carolina under the Liberalized 1967 Law*, N.C. Med. J. 186, 194 (May, 1971)).
Virginia: Bureau of Maternal Health, Department of Health (unpublished material). (Time period for therapeutic abortion is July to December, 1970; the number of therapeutic abortions was adjusted accordingly).
Maryland: Maternity and Family Planning Section, Department of Health (unpublished material). (Therapeutic abortion data is for fiscal years).
Delaware: Division of Physical Health, Department of Health and Social Services, Report of Abortions, 1970.
Colorado: Statistics Section, Department of Health, Summary Statistics Therapeutic Abortions, March 4, 1971.
New Mexico: Data gathered by Professor Robert Munsick for Conference on Abortion, Sterilization, and Population, (University of New Mexico, February, 1971). (Time period for therapeutic abortion is five, six or seven months period, depending upon the hospital; the number of therapeutic abortions was adjusted accordingly).
Oregon: State Board of Health, Therapeutic Abortions Occurring in Oregon Hospitals, 1969; and 1970, February 26, 1970; and February 25, 1971.
California: Department of Public Health and personal communication from Mrs. T. Hunt.

3. "Out-of-State Abortions" are those performed outside of the woman's state of residence. The "% of Residents' Abortions Received Out-of-State" was calculated from data in C. Tyler, J. Bourne, S. Conger, and J. Kahn, Reporting and Surveillance of Legal Abortions in the United States, 1970 (Center for Disease Control, HEW) (June 3, 1971) Figure 2.

The "Number of Residents Received Abortions in New York City, July, 1970 - March, 1971" is based on statistics issued by the Health Services Administration, The City of New York, June 29, 1971.

4. "Counties Lacking Facilities Required by Law for Therapeutic Abortion" are those counties which lack the medical facilities

specified by the particular state statute for the legal performance of therapeutic abortion.

All twelve A.L.I. Model Penal Code-type states require that abortions be performed in state licensed hospitals. The sources for state licensed hospitals was obtained from the state when possible.

Georgia: Licensure Service, Department of Public Health, Licensed Hospitals in Georgia, April 1, 1971.
Virginia: Bureau of Medical and Nursing Facilities Services, State Department of Health, Virginia Hospitals, January, 1971.
New Mexico: Health Facilities Services Division, Health and Social Services Department, Hospital Facilities in New Mexico, March, 1970.
California: Bureau of Health Facilities Licensing Certification, State Department of Public Health, Hospitals, Homes, and Related Health Facilities, March 31, 1970.
Otherwise, the *Guide Issue*'s "general" hospital classification was used.

Of all twelve states, all but South Carolina, North Carolina, New Mexico and Oregon require that the procedure occur in an accredited hospital as well. Of these eight states, the group which accredits the hospital must be the Joint Commission on Accreditation of Hospitals, except in Delaware, where accreditation must be "by a nationally recognized hospital accrediting authority". The source of accreditation of hospitals was the *Guide Issue*, (1970).

5. The source for "Unmet Family Planning Needs by County" ("Per cent Medically Indigent Women Without Family Planning Program" and "Illegitimate Births per 1000 Live Births") is Family Planning Program, Office of Economic Opportunity, Need for Subsidized Family Planning Services: United States, Each State and County, 1968. "Medically indigent women" as defined by this source are those women of child bearing age who are unable to afford private medical care. The county-by-county statistics from this source are based on the county of residence of the woman. The therapeutic abortion data used herein (See note 2) are based on the county of occurence of abortions and births. This difference accounts for the apparent inconsistencies in Table III (such as illegitimate birth rates for counties in which no births took place).

6. The figures in Tables II-A to II-J have been percentagized vertically; that is, under the appropriate column, "Metropolitan County" or "Non-Metropolitan County." *E.g.*, if a state consisted of ten counties (5 metropolitan and 5 non-metropolitan) of which only one metropolitan county had no therapeutic abortions in 1970, the percentage listed in the "Metropolitan County" column for "No.

T.A.'s in 1970" would be 20%, meaning that one county of the five metropolitan counties fit this category. However, the two key rows "Number of Metrop. and Non-Metrop. Counties" and "Number of Licensed General Hospitals" have been percentagized horizontally.

7. The abbreviation "NA" in Table III indicates that a hospital is not accredited by the Joint Commission on Hospital Accreditation. All other listed hospitals, in the states which require accreditation, are accredited.

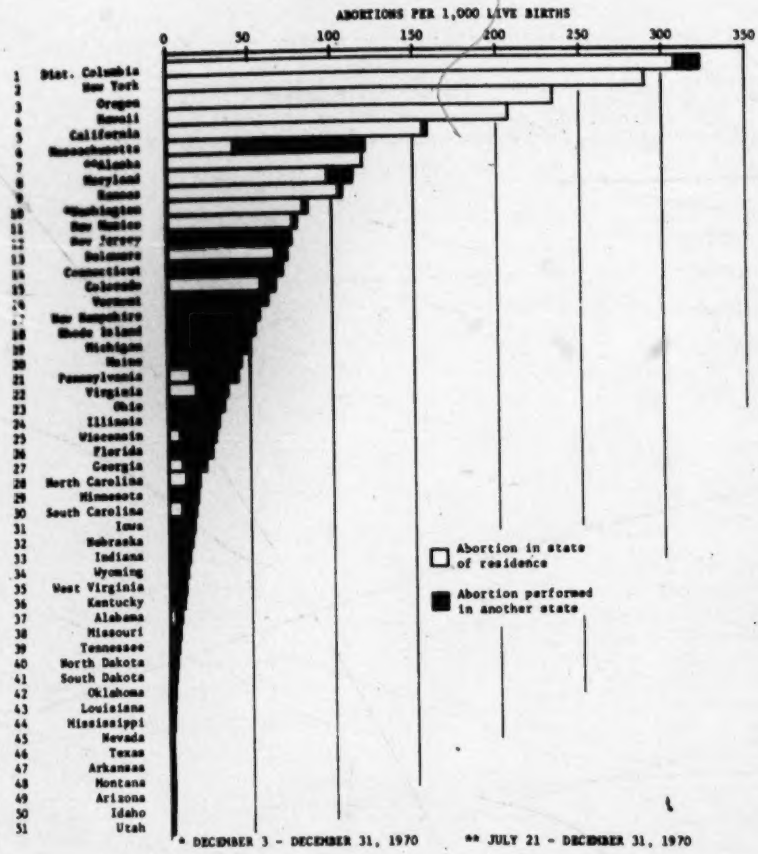
I.

Summary of Statutes and Statistical Data on Therapeutic Abortion in States With A.L.I. Model Penal Code-Type Statutes.

	"Life"		PENALTY	OTHER SIGNIFICANT PROVISIONS
ance of Fair st	x**		1 to 5 yrs.; 1 to 10 yrs. where beyond 26 weeks	
.. Co A (1), t S	x	ie (b) 5.	1 to 10 yrs.	
SO.. Co or S 16-87 1	x			
RO N tion of Ae life - said (a L N	x		1 to 10 yrs. fined at discretion of the court	
VId Va l or 6 1 1	x	ed vit	1 to 10 yrs.	Husband must consent to abortion if it is being performed because of fetal defect.
MAtion Anir the Are 10	x		not more than $5,000, or 3 years, or both	

**"x"
a th

FIGURE I-2. RATIOS OF REPORTED LEGAL ABORTIONS TO LIVE BIRTHS BY STATE OF RESIDENCE, JULY-DECEMBER, 1970



From: Tyler et al., Reporting and Surveillance of Legal Abortions in the United States (Center for Disease Control, HEW) (June 3, 1971).

TABLE I-3,

INDICATIONS FOR WHICH THERAPEUTIC ABORTIONS WERE PERFORMED IN STATES WITH A.L.I. MODEL PENAL CODE-TYPE STATUTES

STATE Time period	Indications						
	% Mental Health	% Physical Health	% Fetal Defects	% Rape or Incest	% Other	% Socio-economic Hardship	% Contra-ception Fail
GEORGIA							
1968	41%	22%	33%	4%	-	-	-
1969	61	14	17	5	2	-	1
1970	72	10	5	2	1	9	1
1971 (1st qtr.)	43	14	1	2	1	34	6
S. CAROLINA							
1970 Feb/June	78.6	14.3	6.4	0.7	0		
N. CAROLINA							
1967	46	36	14	4	0		
1968	47	37	14	3	0		
1969	69	21	7	3	2		
1970	88	10	1	1	0		
VIRGINIA							
1970 July/Jan	87	4	1	0+	8		
1971 Jan/May	94	3	1	1	2		
MARYLAND							
1969 (FY)	91.6	5.7	1.8	0.7	0.2		
1970 (FY)	97	2	1	0+	0+		
DELAWARE							
1969 June/Dec	94.4 [not differentiated]		5.6	0	0		
1970	98		1	0+	0+		
COLORADO							
1968	57	14	-	12	17		
1969	73	14	-	8	4		
1970	89	7	-	3	1		
OREGON							
1969	79	4	[combined: 1]		15		
1970	93	5	1	1	0+		
CALIFORNIA							
1969	94	2	-	4	-		
1970	98	1	-	1	-		

*Following the decision in *Doe v. Bolton* striking down portions of the Georgia statute, the categories of indications were expanded by the Georgia Department of Public Health in their reports.

II.

Summary of Steps By States on Implementation of A.L.I. Model Penal Code-Type Therapeutic Abortion Statutes.

TABLE II-A.

GEORGIA: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1968-1970

	STATE TOTALS	METROPOLITAN[6] COUNTIES	NON-METROPOLITAN[6] COUNTIES
# of T.A.'s	939	863	76
# of Births	236,065	133,959	102,106
T.A. Ratio	4.0	7.6	0.7
Distribution of T.A.'s in State	-	92%	8%
Distribution of Births in State	-	57%	43%
# [and %] of Metrop. and Non-Metrop. Counties	159	13(8%)	146(92%)
# [and %] of Counties with No T.A.'s in 1970	129(81%)	4(31%)	125(86%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	153(96%)	7(54%)	146(100%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	103(65%)	5(38%)	98(67%)
# of Licensed General Hospitals	150	29(19%)	121(81%)
# [and %] of Non-Accredited (JCAH) Hospitals	79 (53%)	8(28%)	71(59%)

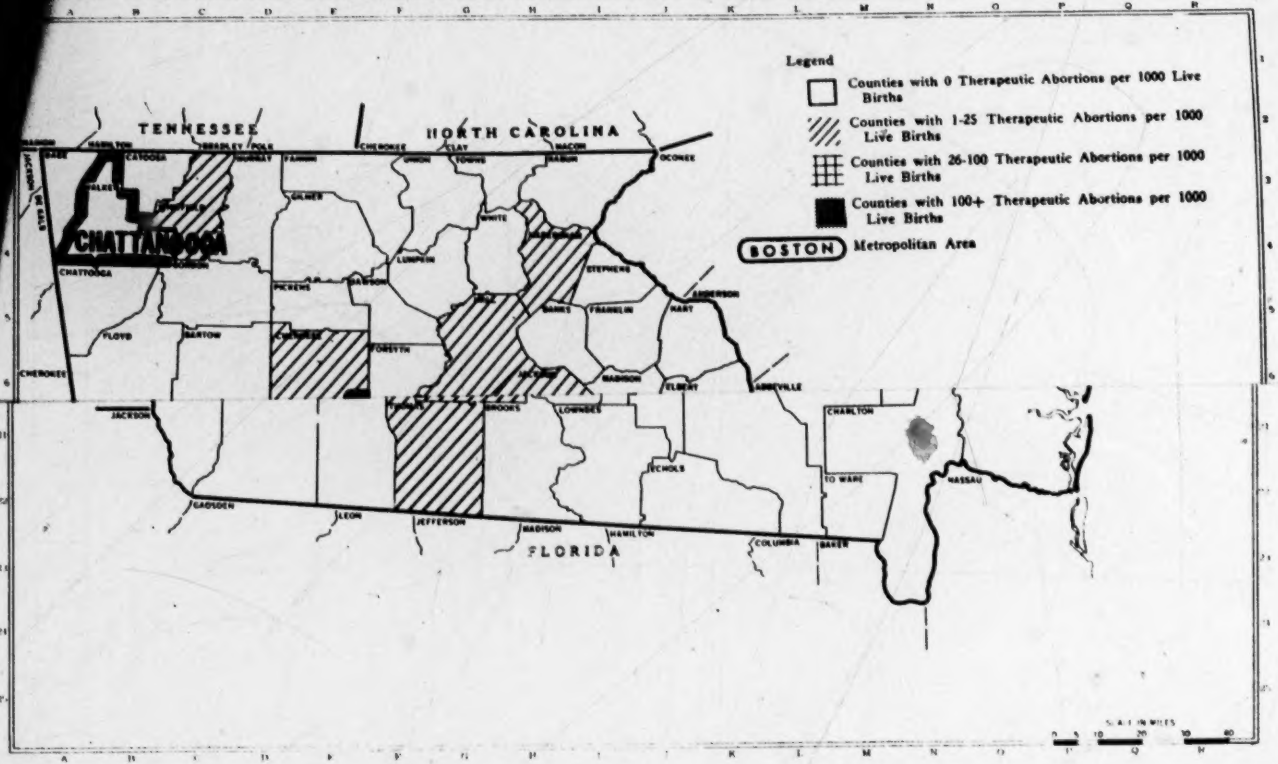

Legend
Counties with 0 Therapeutic Abortions per 1000 Live Births
Counties with 1-25 Therapeutic Abortions per 1000 Live Births
Counties with 26-100 Therapeutic Abortions per 1000 Live Births
Counties with 100+ Therapeutic Abortions per 1000 Live Births
BOSTON Metropolitan Area
TENNESSEE
NORTH CAROLINA
CHATTANOOGA
FLORIDA

TABLE II-B.

SOUTH CAROLINA: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	684	538	146
# of Births	44,648	17,138	27,510
T.A. Ratio	15.3	31.4	5.3
Distribution of T.A.'s in State	-	79%	21%
Distribution of Births in State	-	38%	62%
# [and %] of Metrop. and Non-Metrop. Counties	46	5(11%)	41(89%)
# [and %] of Counties with No T.A.'s in 1970	24(52%)	1(20%)	23(56%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	39(85%)	2(40%)	37(90%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	6(13%)	1(20%)	5(12%)
# of Licensed General Hospitals	69	16 (23%)	53 (77%)
# [and %] of Hospitals With No T.A.'s in 1970	32(46%)	6(38%)	26(49%)
# [and % of State Total] of T.A.'s Performed by 3 Hospitals with Greatest Number of T.A.'s in 1970	487(71%)	-	-



Legend

- Counties with 0 Therapeutic Births
- Counties with 1-25 Therapeu Live Births
- Counties with 26-100 Therape Live Births
- Counties with 100+ Therapeu Live Births
- BOSTON Metropolitan Area

SCALE IN MILES

TABLE II-C

NORTH CAROLINA: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1967-1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	1687	743	944
# of Births	354,987	108,542	246,445
T.A. Ratio	4.8	6.8	3.8
Distribution of T.A.'s in State	-	44%	56%
Distribution of Births in State	-	31%	69%
# [and %] of Metrop. and Non-Metrop. Counties	100	6(6%)	94(94%)
# [and %] of Counties with No T.A.'s in 1970	47(47%)	0(0%)	47(50%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	79(79%)	0(0%)	79(84%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	15(15%)	0(0%)	15(16%)
# of Licensed General Hospitals	141	22(16%)	119(84%)
# [and %] of Hospitals With No T.A.'s in 1970	72(51%)	9(41%)	63(53%)
# [and % of State Total] of T.A.'s Performed by 5 Hospitals with Greatest Number of T.A.'s in 1970	1184(70%)		

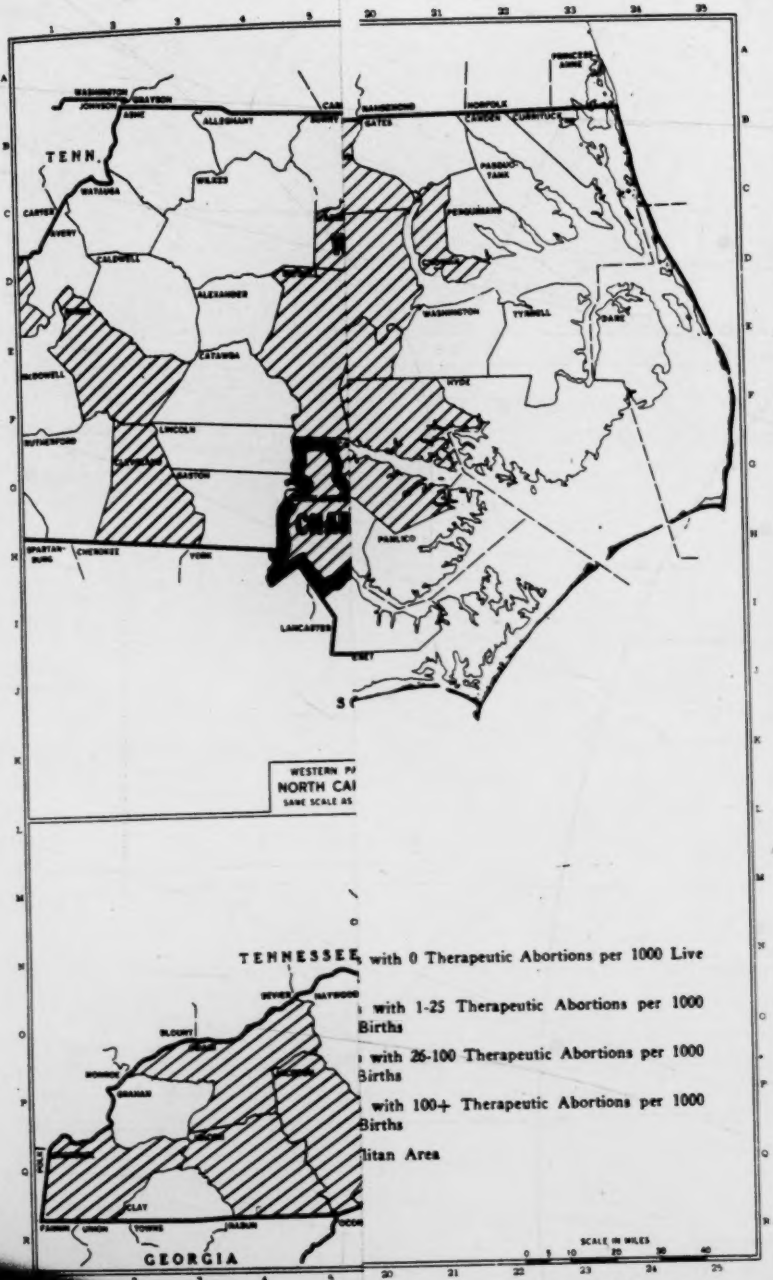
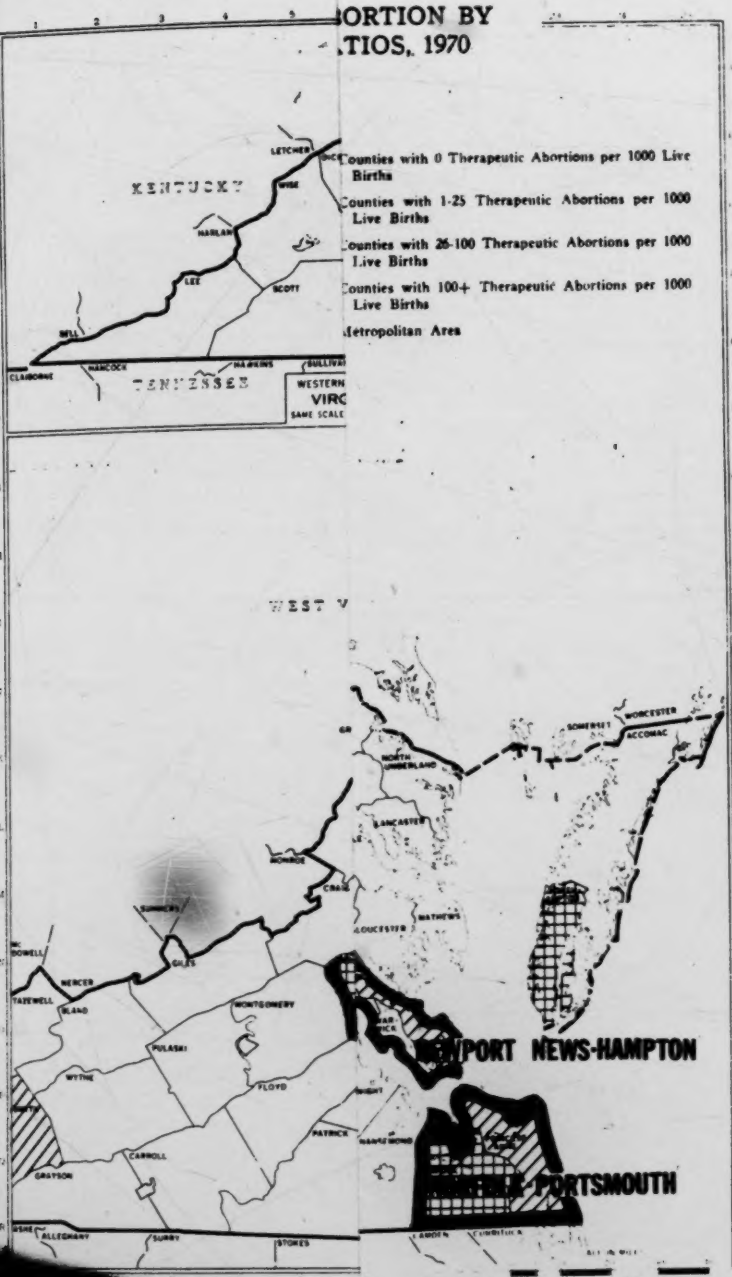

TENN.
WESTERN PI
NORTH CAI
SAME SCALE AS
TENNESSEE
GEORGIA
with 0 Therapeutic Abortions per 1000 Live
with 1-25 Therapeutic Abortions per 1000
Births
with 26-100 Therapeutic Abortions per 1000
Births
with 100+ Therapeutic Abortions per 1000
Births
litan Area
SCALE IN MILES

TABLE II-D

VIRGINIA: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	2,214	1,924	290
# of Births	64,787	37,478	27,309
T.A. Ratio	34.2	51.3	10.6
Distribution of T.A.'s in State	-	87%	13%
Distribution of Births in State	-	58%	42%
# [and %] of Metrop. and Non-Metrop. Counties	99	10(10%)	89(90%)
# [and %] of Counties with No T.A.'s in 1970	79(80%)	3(30%)	76(85%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	90(91%)	4(40%)	86(97%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	54(55%)	2(20%)	52(58%)
# of Licensed General Hospitals	110	44(40%)	66(60%)
# [and %] of Non-Accredited (JCAH) Hospitals	43(39%)	5(11%)	38(58%)

ORTION BY
TIOS, 1970



Counties with 0 Therapeutic Abortions per 1000 Live Births

Counties with 1-25 Therapeutic Abortions per 1000 Live Births

Counties with 26-100 Therapeutic Abortions per 1000 Live Births

Counties with 100+ Therapeutic Abortions per 1000 Live Births

Metropolitan Area

TABLE II-E

MARYLAND: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1969-1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	7,667	7,442	225
# of Births	111,290	89,582	21,708
T.A. Ratio	68.9	83.1	10.4
Distribution of T.A.'s in State	-	97%	3%
Distribution of Births in State	-	80%	20%
# [and %] of Metrop. and Non-Metrop. Counties	24	7(29%)	17(71%)
# [and %] of Counties with No T.A.'s in 1970	8(33%)	1(14%)	7(41%)
# [and %] of Counties With 10 or fewer T.A.'s in 1970	15(68%)	3(43%)	12(71%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	6(25%)	1(14%)	5(29%)
# of Licensed General Hospitals	42	26(62%)	16(38%)
# [and %] of Non-Accredited (JCAH) Hospitals	3(7%)	1(4%)	2(12%)
# [and %] of Hospitals With No T.A.'s in 1970	15(36%)	8(31%)	7(44%)
# [and % of State Total] of T.A.'s Performed by 5 Hospitals with Greatest Number of T.A.'s in 1970	5,536(72%)		

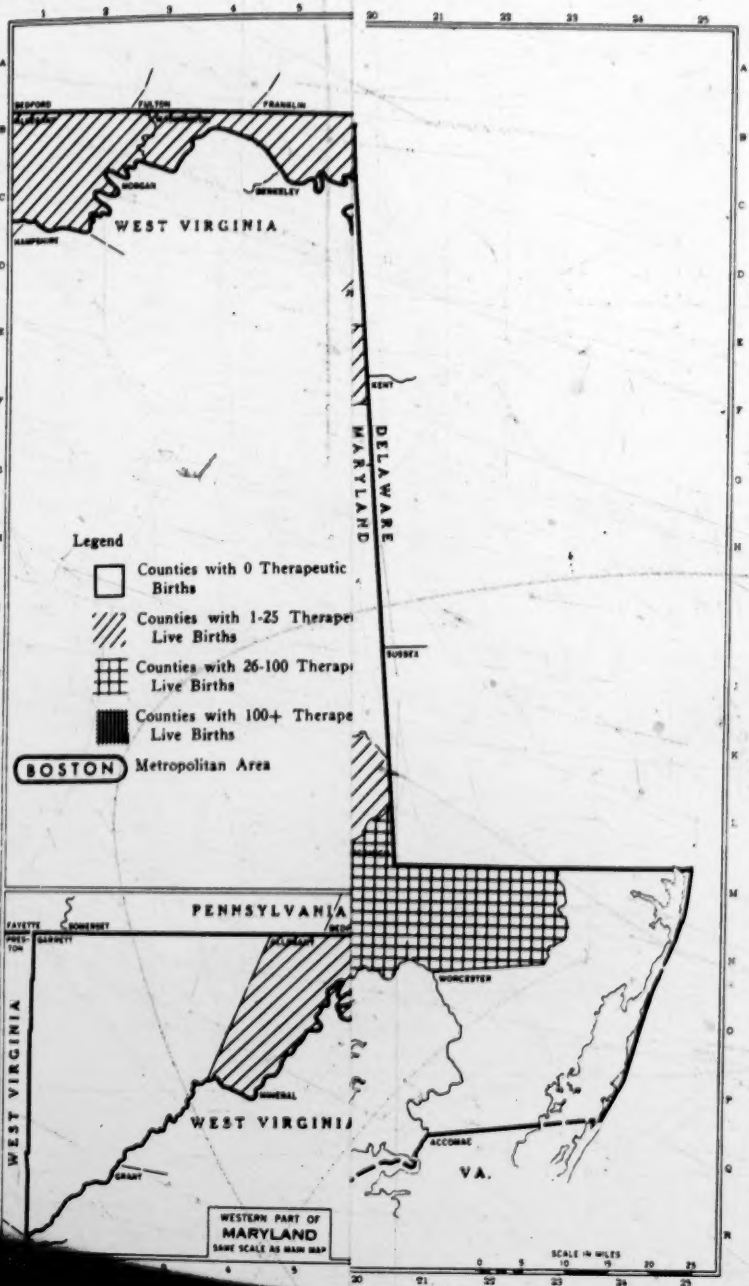

WEST VIRGINIA
MARYLAND
DELAWARE
PENNSYLVANIA
WEST VIRGINIA
WEST VIRGINIA
VA.
Legend
Counties with 0 Therapeutic Births
Counties with 1-25 Therapeutic Live Births
Counties with 26-100 Therapeutic Live Births
Counties with 100+ Therapeutic Live Births
BOSTON
Metropolitan Area
WESTERN PART OF MARYLAND
SAME SCALE AS MAIN MAP
SCALE IN MILES

TABLE II-P.

DELAWARE: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	558	525	33
# of Births	9,287	6,878	2,409
T.A. Ratio	60.1	76.3	13.7
Distribution of T.A.'s in State	-	94%	6%
Distribution of Births in State	-	74%	26%
# [and %] of Metrop. and Non-Metrop. Counties	3	1(33%)	2(67%)
# [and %] of Counties with No T.A.'s in 1970	0(0%)	0(0%)	0(0%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	0(0%)	0(0%)	0(0%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	0(0%)	0(0%)	0(0%)
# of Licensed General Hospitals	7	3(43%)	4(44%)
# [and %] of Non-Accredited (JCAH) Hospitals	0(0%)	0(0%)	0(0%)
# [and %] of Hospitals With No T.A.'s in 1970	1(14%)	1(33%)	0(0%)
# [and % of State Total] of T.A.'s Performed by Hospital with Greatest Number of T.A.'s in 1970	522(94%)	-	-

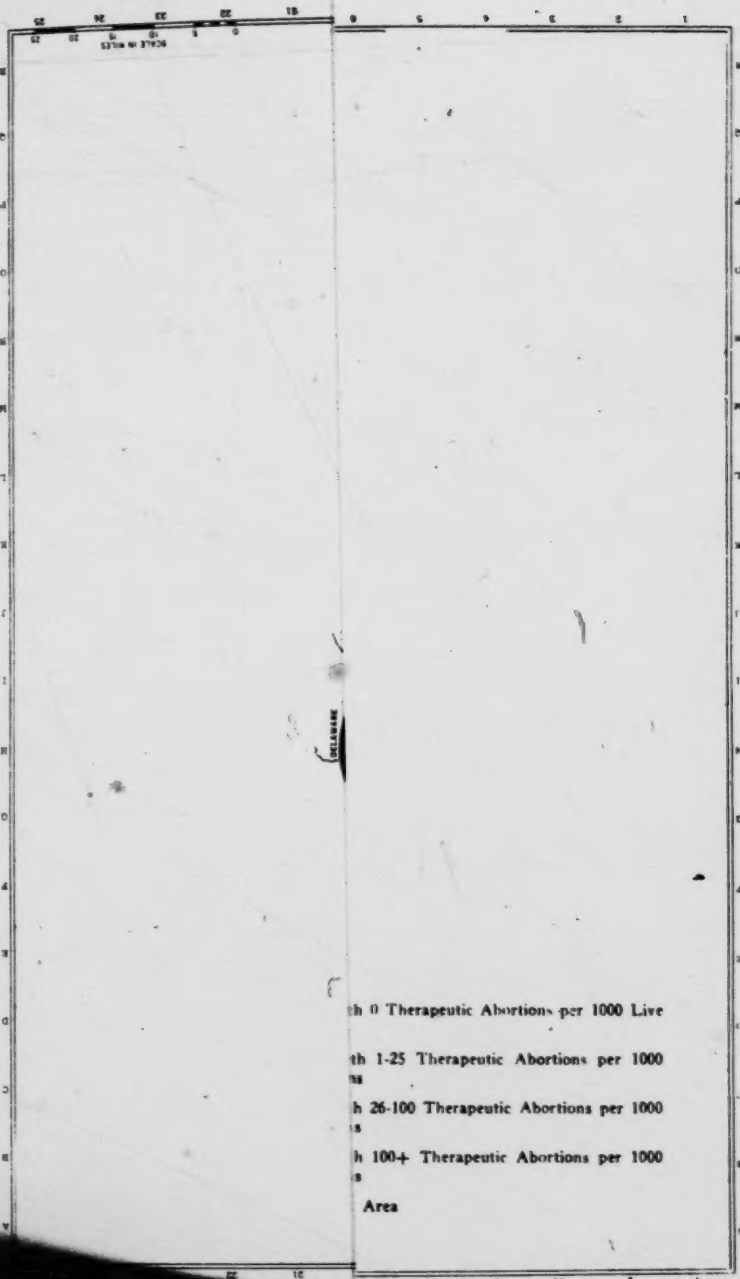

th 0 Therapeutic Abortions per 1000 Live
th 1-25 Therapeutic Abortions per 1000
h 26-100 Therapeutic Abortions per 1000
h 100+ Therapeutic Abortions per 1000
Area

TABLE II-G.

COLORADO: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1967-1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	3,900	3,819	81
# of Births	140,664	107,034	33,630
T.A. Ratio	27.7	35.7	2.4
Distribution of T.A.'s in State	-	98%	2%
Distribution of Births in State	-	76%	24%
# [and %] of Metrop. and Non-Metrop. Counties	63	7(11%)	56(89%)
# [and %] of Counties with No T.A.'s in 1970	48(76%)	0(0%)	48(86%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	54(86%)	1(14%)	53(95%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	39(62%)	0(0%)	39(70%)
# of Licensed General Hospitals	72	25(35%)	47(65%)
# [and %] of Non-Accredited (JCAH) Hospitals	30(42%)	4(16%)	26(55%)
# [and %] of Hospitals With No T.A.'s in 1970	50(69%)	10(40%)	40(85%)
# [and % of State Total] of T.A.'s Performed by 6 Hospitals with Greatest Number of T.A.'s in 1970	1913(78%)	-	-

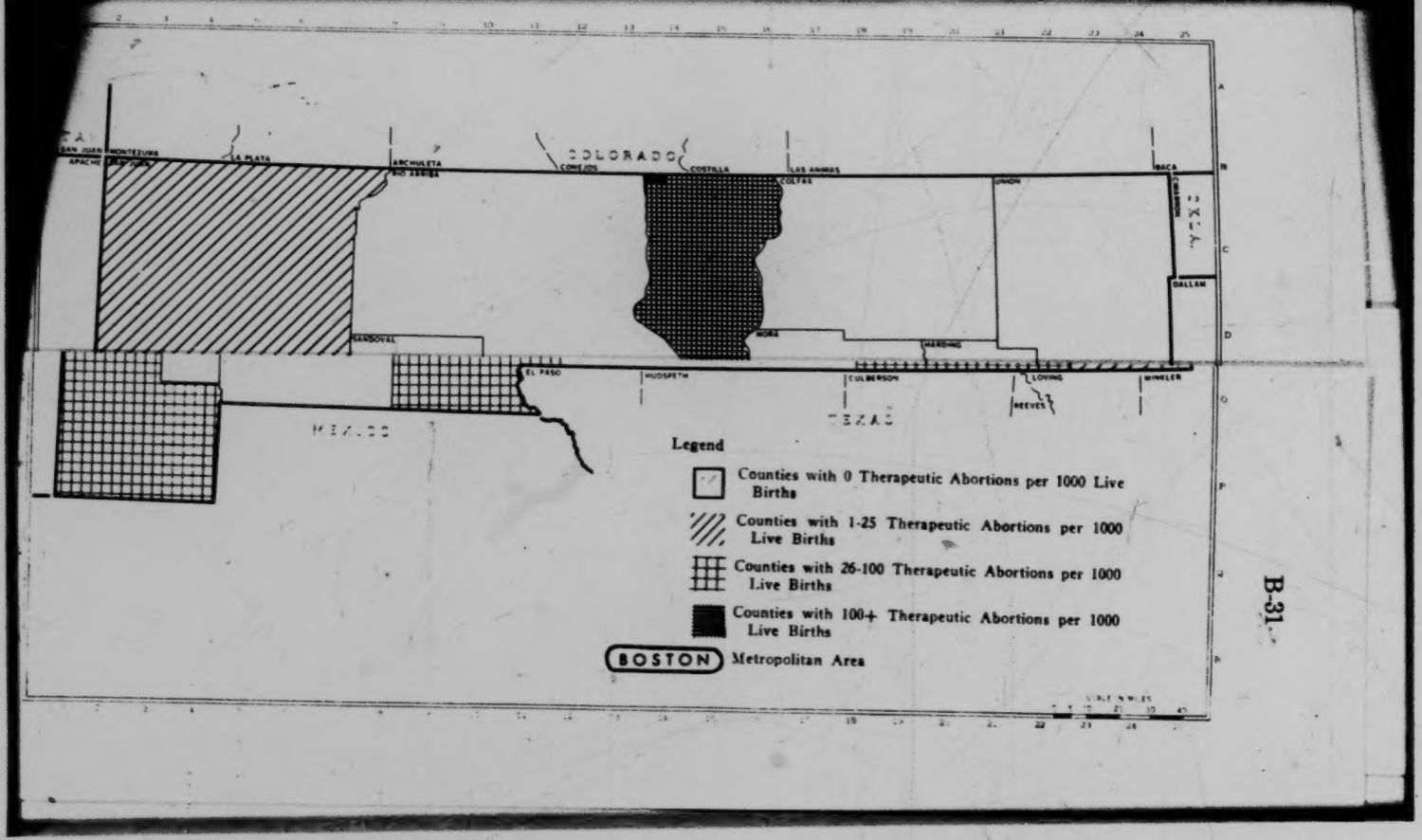

Counties with 0 Therapeutic Abortions per 1000 Live Births
Counties with 1-25 Therapeutic Abortions per 1000 Live Births
Counties with 26-100 Therapeutic Abortions per 1000 Live Births
Counties with 100+ Therapeutic Abortions per 1000 Live Births
BOSTON Metropolitan Area
MONTEZUMA
DOLORES
SAN MIGUEL
MESA
MONTROSE
OURAY
SAN JUAN
HINSDALE
DELTA
GUNNISON
SAGUACHE
CHAFFEE
FREMONT
PARK
TELLER
EL PASO
CUSTER
HUERFANO
LAS ANIMAS
BENT
PROWERS
KIT CARSON
CROWLEY
OTERO
KIOWA
BACA
PUEBLO
SCALE IN MILES
0 5 10 20 30 40
B-28

TABLE II-H

NEW MEXICO: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	1,300	1,040	259
# of Births	17,264	5,942	11,322
T.A. Ratio	75.3	175.2	22.9
Distribution of T.A.'s in State	-	80%	20%
Distribution of Births in State	-	34%	66%
# [and %] of Metrop. and Non-Metrop. Counties	32	1(3%)	31(97%)
# [and %] of Counties with No T.A.'s in 1970	22(69%)	0(0%)	22(71%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	25(78%)	0(0%)	25(81%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	13(41%)	0(0%)	13(42%)
# of Licensed General Hospitals	43	7(16%)	36(84%)
# [and %] of Hospitals With No T.A.'s in 1970	28(65%)	3(43%)	25(69%)
# [and % of State Total] of T.A.'s Performed by the Hospitals with Greatest Number of T.A.'s in 1970	3 1,058(81%)		



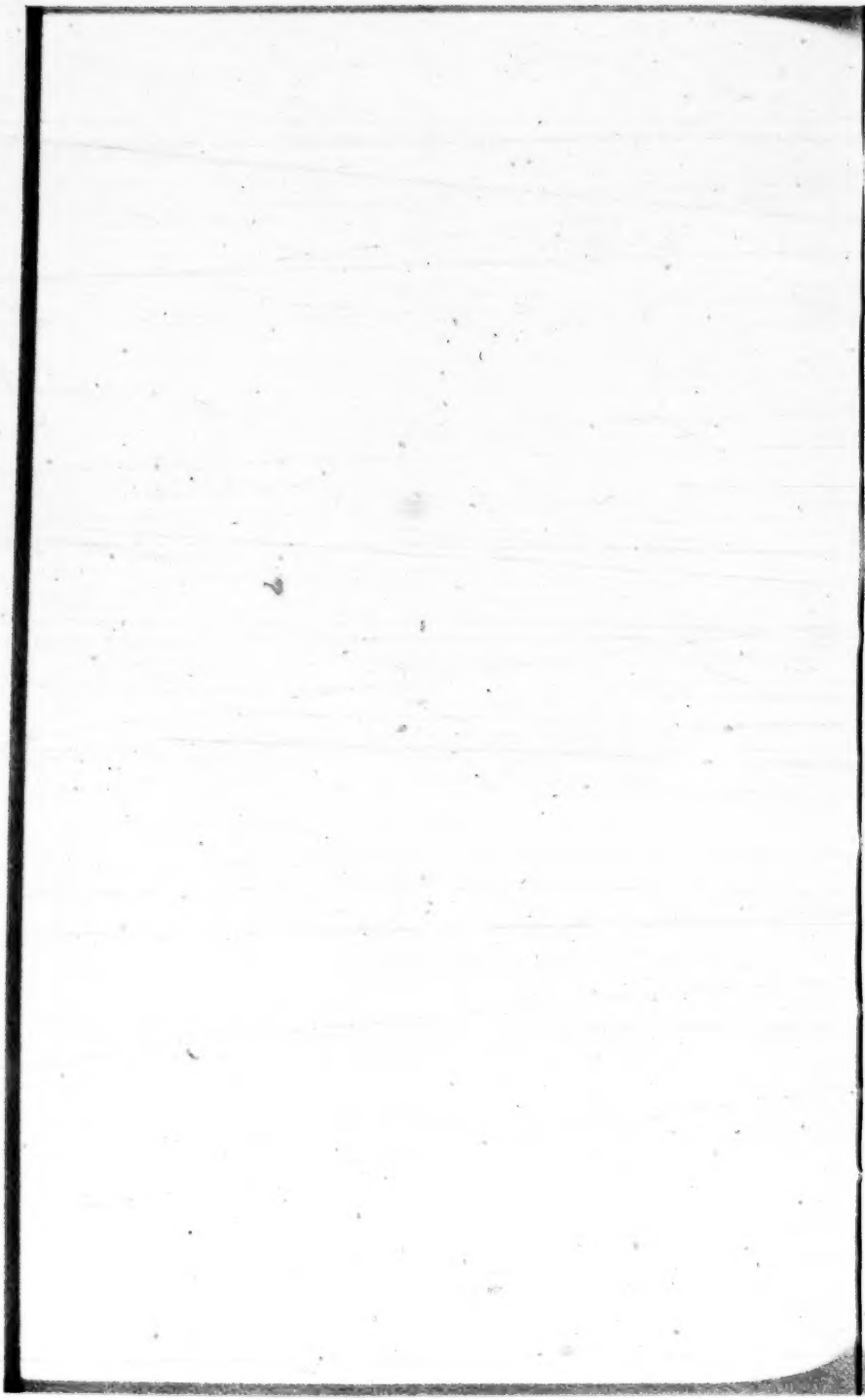

COLORADO
TEXAS
NEW MEXICO
SAN JUAN
MONTEZUMA
APACHE
LA PLATA
ARCHULETA
RIO ARRIBA
CONEJOS
COSTILLA
LAS ANIMAS
BACA
PROWERS
BENT
OTERO
KIOWA
CROWLEY
LINCOLN
EL PASO
HUDSPETH
CULBERSON
LOVING
WINKLER
REEVES
Legend
Counties with 0 Therapeutic Abortions per 1000 Live Births
Counties with 1-25 Therapeutic Abortions per 1000 Live Births
Counties with 26-100 Therapeutic Abortions per 1000 Live Births
Counties with 100+ Therapeutic Abortions per 1000 Live Births
BOSTON Metropolitan Area

B-31

TABLE II-I

OREGON: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1969-1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	8,603	7,708	895
# of Births	68,764	14,674	54,090
T.A. Ratio	125.1	525.3	16.5
Distribution of T.A.'s in State	-	90%	10%
Distribution of Births in State	-	21%	79%
# [and %] of Metrop. and Non-Metrop. Counties	36	4(11%)	32(89%)
# [and %] of Counties with No T.A.'s in 1970	8(22%)	0(0%)	8(25%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	19(53%)	0(0%)	19(59%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	3(8%)	0(0%)	3(9%)
# [and % of State Total] of T.A.'s Performed by 5 Hospitals with Greatest Number of T.A.'s in 1970	6,143(71%)	-	-



BLEED THROUGH

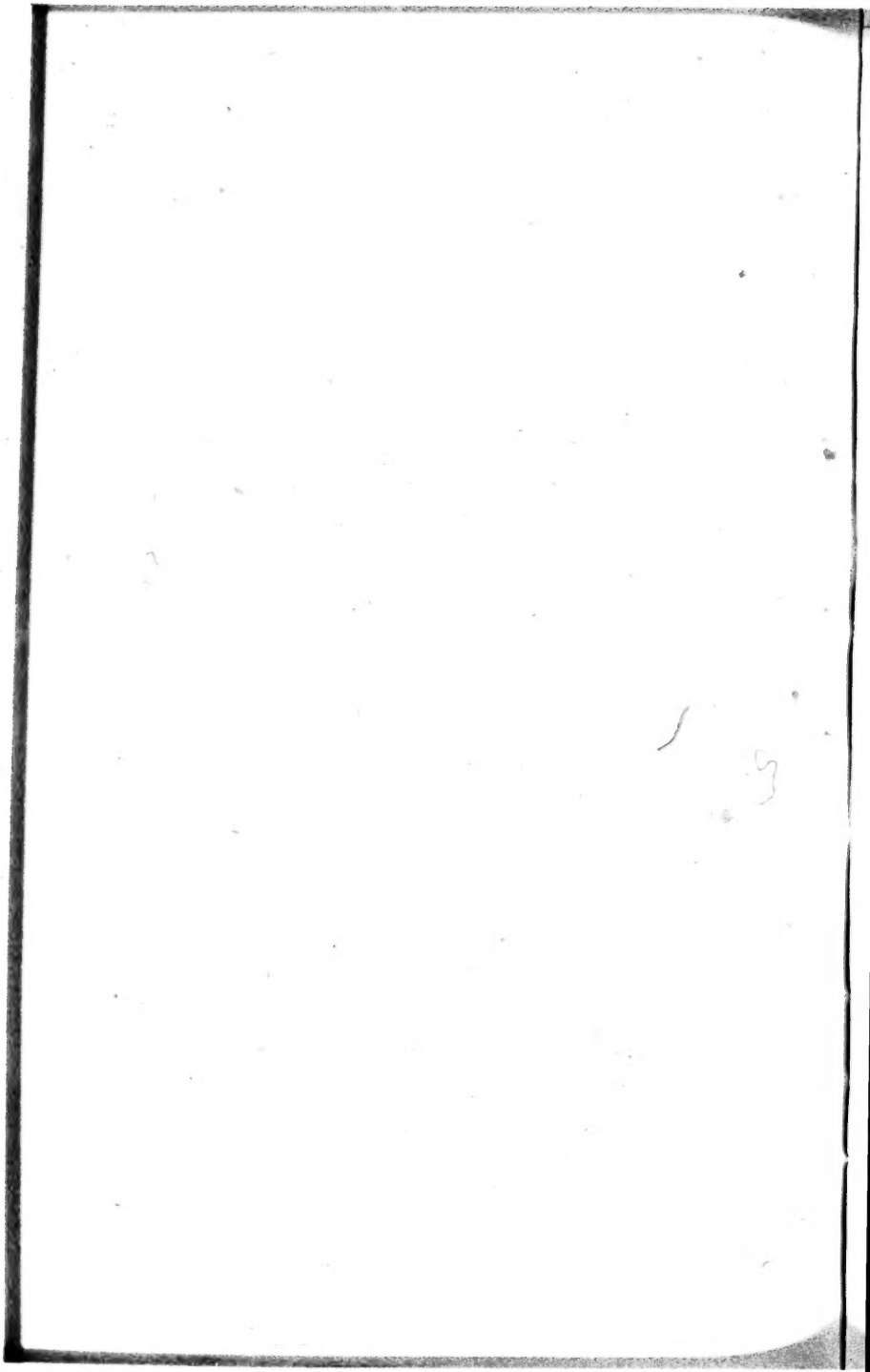
POOR COPY

PREVIOUS FOLDOUTS TOO
LARGE FOR FILMING

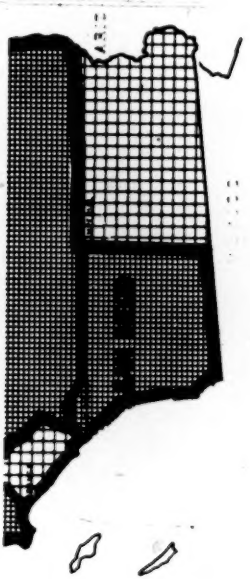
TABLE II-J

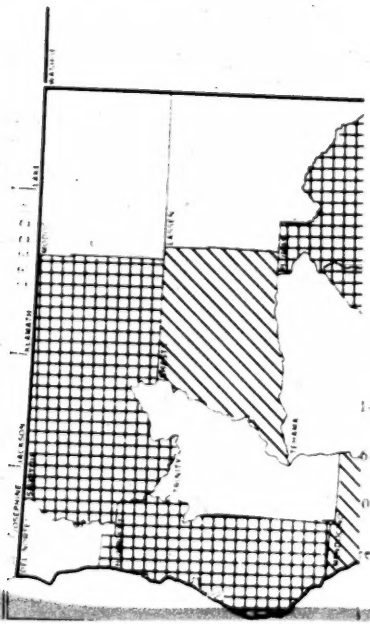
CALIFORNIA: SUMMARY OF DATA ON IMPLEMENTATION OF THERAPEUTIC ABORTION ACT, 1970

	STATE TOTALS	METROPOLITAN COUNTIES	NON-METROPOLITAN COUNTIES
# of T.A.'s	62,672	59,842	2,830
# of Births	322,464	286,098	36,366
T.A. Ratio	194.2	209.2	77.8
Distribution of T.A.'s in State	-	95%	5%
Distribution of Births in State	-	89%	11%
# [and %] of Metrop. and Non-Metrop. Counties	58	17(29%)	41(71%)
# [and %] of Counties with No T.A.'s in 1970	14(24%)	0(0%)	14(34%)
# [and %] of Counties With 10 or Fewer T.A.'s in 1970	22(38%)	0(0%)	22(54%)
# [and %] of Counties Lacking Facilities Required by Law for T.A.'s	8(14%)	0(0%)	8(20%)
# of Licensed General Hospitals	518	374(72%)	144(28%)
# [and %] of Non-Accredited (JCAH) Hospitals	75(15%)	37(10%)	38(26%)



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Therapeutic Abortions per 1000 Live

1-25 Therapeutic Abortions per 1000

6-100 Therapeutic Abortions per 1000

00+ Therapeutic Abortions per 1000

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PREVIOUS FOLDOUTS TOO
LARGE FOR FILMING

III.

Detailed Data on Distribution of Therapeutic Abortion By County and Medical Facility in States With A.L.I. Model Penal Code-Type Statutes.

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	88	--	939	236,065	4.0		
APPLING	91		0	444	0	0	0.2
ATKINSON	87		0	0	0	0	0
BACON	97		0	0	0	0	0
BAKER	92		0	0	0	0	0
BALDWIN	93		0	772	0	0	0.3
BANKS	97		0	0	0	0	0
BARROW	95		0	885	0	0	0.4
BARTOW	98		0	1,347	0	0	0.6
BEN HILL	79		0	0	0	0	0
BERRIEN	94		0	95	0	0	0+
BIBB	91		37	9,033	4.1	3.9	3.8
BLECKLEY	92		0	0	0	0	0
BRANTLEY	96		0	0	0	0	0
BROOKS	91		0	0	0	0	0
BRYAN	94		0	0	0	0	0
BULLOCH	95		0	1,552	0	0	0.7
BURKE	98		0	387	0	0	0.2
BUTTS	76		0	230	0	0	0.1
CALHOUN	98		0	0	0	0	0
CAMDEN	94		0	327	0	0	0.1
CANDLER	92		0	0	0	0	0

TABLE III-A

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CARROLL	100	--	0	3,748	0	0	1.6
CATOOSA	98		0	2,826	0	0	1.9
CHARLTON	97		0	411	0	0	0.2
CHATHAM	88		76	9,059	8.4	8.0	3.8
CHATTAHOOCHEE	--		0	0	0	0	0
CHATTOOGA	97		0	468	0	0	0.2
CHEROKEE	100		2	1,038	1.9	0.2	0.5
CLARKE	90		9	5,519	1.6	0.9	2.3
CLAY	53		0	226	0	0	0.1
CLAYTON	97		0	0	0	0	0
CLINCH	89		0	801	0	0	0.4
COBB	97		12	8,525	1.4	1.2	3.6
COFFEE	92		0	1,387	0	0	0.6
COLQUITT	93		3	1,197	2.5	0.3	0.5
COLUMBIA	100		0	0	0	0	0
COOK	91		0	566	0	0	0.2
COWETA	90		5	2,391	2.1	0.5	1.0
CRAWFORD	76		0	0	0	0	0
CRISP	92		0	835	0	0	0.4
DADE	95		0	0	0	0	0
DAWSON	100		0	0	0	0	0

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
DECATUR	96	--	0	931	0	0	0.4
DE KALB	71		13	34,782	0.4	1.3	14.7
DODGE	99		1	0	--	0.1	0
DOOLY	96		0	0	0	0	0
DOUGHERTY	98		3	5,683	0.6	0.3	2.4
DOUGLAS	98		0	0	0	0	0
EARLY	99		0	460	0	0	0.2
ECHOLS	99		0	0	0	0	0
EFFINGHAM	98		0	0	0	0	0
ELBERT	99		0	687	0	0	0.3
EMANUEL	97		0	785	0	0	0.3
EVANS	86		0	56	0	0	0+
FANNIN	100		0	0	0	0	0
FAYETTE	91		0	0	0	0	0
FLOYD	98		1	6,394	0.2	0.1	2.7
FORSYTH	98		0	0	0	0	0
FRANKLIN	100		0	0	0	0	0
FULTON	59		595	33,389	17.8	63.2	14.1
GILMER	97		0	369	0	0	0.2
GLASCOCK	51		0	0	0	0	0
GLYNN	97		1	3,332	0.3	0.1	1.4
GORDON	99		0	782	0	0	0.3

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
GRADY	93	--	0	598	0	0	0.2
GREENE	90		0	379	0	0	0.1
GWINNETT	97		0	2,038	0	0	0.9
HABERSHAM	95		1	741	1.3	0.1	0.3
HALL	98		13	10,760	1.2	1.3	4.6
HANCOCK	90		0	0	0	0	0.1
HARALSON	96		0	242	0	0	0.1
HARRIS	84		0	0	0	0	0
HART	88		0	259	0	0	0.1
HEARD	91		0	195	0	0	0.1
HENRY	93		0	0	0	0	0
HOUSTON	94		3	1,754	1.7	0.3	0.7
IRWIN	93		0	0	0	0	0
JACKSON	94		4	943	4.2	0.4	0.4
JASPER	78		0	0	0	0	0
JEFF DAVIS	97		0	598	0	0	0.2
JEFFERSON	99		0	0	0	0	0
JENKINS	85		0	401	0	0	0.2
JOHNSON	92		0	0	0	0	0
JONES	93		0	0	0	0	0
LAMAR	88		0	0	0	0	0
LANIER	87		0	220	0	0	0.1

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
LAURENS	91	--	2	1,955	1.0	0.2	0.7
LEE	97		0	0	0	0	0
LIBERTY	92		0	234	0	0	0.1
LINCOLN	99		0	0	0	0	0
LONG	97		0	0	0	0	0
LOWNDES	90		0	2,607	0	0	1.1
LUMPKIN	99		0	0	0	0	0
McDUFFIE	99		0	415	0	0	0.2
McINTOSH	100		0	0	0	0	0
MACON	96		0	241	0	0	0.1
MADISON	98		0	0	0	0	0
MARION	97		0	0	0	0	0
MERIWETHER	86		0	961	0	0	0.7
MILLER	100		0	0	0	0	0
MITCHELL	90		0	0	0	0	0
MONROE	88		0	435	0	0	0.2
MONTGOMERY	98		0	0	0	0	0
MORGAN	96		0	595	0	0	0.3
MURRAY	100		0	0	0	0	0
MUSCOGEE	82		3	7,387	0.4	0.3	3.1
NEWTON	95		8	1,174	6.8	0.8	0.5
OCONEE	86		0	0	0	0	0

TABLE III-A

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
OGLETHORPE	98	--	0	0	0	0	0
PAULDING	93		0	837	0	0	0.4
PEACH	87		2	919	2.2	0.2	0.4
PICKENS	100		0	0	0	0	0
PIERCE	87		0	0	0	0	0
PIKE	83		0	0	0	0	0
POLK	95		0	40-	0	0	0.2
PULASKI	86		0	575	0	0	0.2
PUTNAM	98		0	34	0	0	0+
QUITMAN	99		0	0	0	0	0
RABUN	97		0	124	0	0	0.1
RANDOLPH	84		0	220	0	0	0.1
RICHMOND	85		121	21,882	5.5	12.8	9.3
ROCKDALE	90		0	0	0	0	0
SCHLEY	91		0	0	0	0	0
SCREVEN	80		1	211	4.7	0.1	0.1
SEMINOLE	99		0	221	0	0	0.1
SPALDING	88		1	2,575	0.4	0.1	1.1
STEPHENS	93		0	1,367	0	0	0.6
STEWART	97		0	38	0	0	0+
SUMTER	87		0	1,625	0	0	0.7
TALBOT	94		0	0	0	0	0
TALIAFERRO	86		0	0	0	0	0

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
TATTNALL	98	--	0	0	0	0	0
TAYLOR	96		0	434	0	0	0.2
TELFAIR	95		0	0	0	0	0
TERRELL	100		0	0	0	0	0
THOMAS	91		1	1,818	0.6	0.1	0.8
TIFT	98		6	1,334	4.5	0.6	0.6
TOOMBS	93		0	663	0	0	0.3
TOWNS	100		0	0	0	0	0
TREUTLEN	90		0	150	0	0	0.1
TROUP	91		0	2,406	0	0	1.0
TURNER	99		0	441	0	0	0.2
TWIGGS	88		0	0	0	0	0
UNION	99		0	0	0	0	0
UPSON	100		2	0	--	0.2	0
WALKER	95		0	382	0	0	0.2
WALTON	95		2	892	2.2	0.2	0.4
WARE	96		0	2,206	0	0	0.9
WARREN	78		0	0	0	0	0
WASHINGTON	93		0	644	0	0	0.3
WAYNE	92		0	0	0	0	0
WEBSTER	64		0	0	0	0	0

TABLE III-A.

GEORGIA: DISTRIBUTION OF THERAPEUTIC ABORTION - BY COUNTY, 1968-1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1968-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
WHEELER	89	--	0	0	0	0	0
WHITE	87		0	0	0	0	0
WHITFIELD	95		7	3,619	1.9	0.7	1.5
WILCOX	92		0	0	0	0	0
WILKES	92		0	666	0	0	0.3
WILKINSON	74		0	0	0	0	0
WORTH	97		4	376	6.9	0.4	0.2

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TABLE III- B.

SOUTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	84	143	684	44,648	15.3		
ABBEVILLE	90	156	4	0	-	0.6	0
Abbeville Cnty. Mem.			4	0	-	0.6	0
AIKEN	98	72	10	1,062	9.4	1.5	2.4
Aiken County			10	1,062	9.4	1.5	2.4
ALLENDALE	79	347	0	202	0	0	0.5
Allendale Cnty.			0	202	0	0	0.5
ANDERSON	93	53	6	2,700	2.2	0.9	6.0
Anderson Mem.			5	2,700	1.9	0.7	6.0
Willismston			1	0	-	0.3	0
BAMBERG	84	185	0	242	0	0	0.5
Bamberg Cnty. Mem.			0	242	0	0	0
BARNWELL	92	143	0	218	0	0	0.5
Barnell Cnty.			0	218	0	0	0.5
BEAUFORT	69	239	1	458	2.2	0.1	1.0
Beaufort Cnty. Mem.			1	458	2.2	0.1	1.0
BERKELEY	92	129	0	294	0	0	0.7
Berkeley Cnty.			0	294	0	0	0.7
CALHOUN	76	229	0	0	0	0	0
CHARLESTON	79	167	259	6,510	39.8	37.9	14.6
Baker Mem.			1	182	5.5	0.1	0.4
Charleston Cnty.			78	0	--	11.4	0
McClennan Banks Mem.			0	229	0	0	0.5

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TABLE III-B.

SOUTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
Medical Univ. Hsp. U. of S.C.			167	2,798	59.7	24.4	6.3
Roper			12	2,021	5.9	1.8	4.5
St. Franxis Xavier			0	1,289	0	0	2.9
(Other)			1	0	-	0.1	0
CHEROKEE	98	118	2	945	2.1	0.3	2.1
Cherokee Cnty.Mem.			2	945	2.1	0.3	2.1
CHESTER	77	159	4	685	5.8	0.6	1.5
Chester County			4	685	5.8	0.6	1.5
CHESTERFIELD	44	154	2	422	4.7	0.3	0.9
Chesterfield Cnty.Mem.			2	422	4.7	0.3	0.9
CLARENDON	84	225	0	298	0	0	0.7
Clarendon Mem.			0	298	0	0	0.7
COLLETON	85	146	9	519	17.3	1.3	1.2
Colleton Cnty.			9	519	17.3	1.3	1.2
DARLINGTON	67	155	16	933	17.1	2.3	2.1
Coleman-Aimar			2	245	8.2	0.3	0.5
Wilson Cln.			12	230	52.2	1.8	0.5
Byerly			2	458	4.4	0.3	1.0
DILLON	77	214	0	396	0	0	0.9
St. Eugene			0	396	0	0	0.9
DORCHESTER	93	93	0	266	0	0	0.6
Dorchester Cnty.			0	266	0	0	0.6
EDGEFIELD	75	150	0	0	0	0	0

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TABLE III-B.

SOUTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
FAIRFIELD	97	170	0	255	0	0	0.6
Fairfield Mem.			0	255	0	0	0.6
FLORENCE	93	133	12	662	18.1	1.8	1.5
McCleod Inf.			11	0	-	1.8	0
Saunders Mem.			1	424	2.4	0.1	0.9
Lower Florence Cnty.			0	238	0	0	0.5
GEORGETOWN	94	200	0	784	0	0	1.8
Georgetown Cnty. Mem.			0	784	0	0	1.8
GREENVILLE	89	120	250	5,118	48.8	36.6	11.5
Allen Bennett Mem.			2	881	2.3	0.3	2.0
Greenville Gen.			242	3,382	71.6	35.4	7.6
Hillcrest			6	221	27.1	0.9	0.5
St. Francis Comm.			0	634	0	0	1.4
GREENWOOD	95	126	0	1,438	0	0	3.2
Self Mem.			0	1,438	0	0	3.2
HAMPTON	96	165	0	319	0	0	0.7
Hampton Gen.			0	319	0	0	0.7
HORRY	88	140	39	1,132	34.5	5.7	2.5
Conway			20	718	27.9	2.9	1.6
Louis Comm.			3	414	7.2	0.4	0.9
Ocean View Mem.			16	0	0	2.3	0
JASPER	80	241	0	0	0	0	0
KERSHAW	88	162	17	710	23.9	2.5	1.6
Kershaw Cnty. Mem.			17	710	23.9	2.5	1.6
LANCASTER	70	113	0	1,011	0	0	2.3
Elliott White Spgs. Mem.			0	1,011	0	0	2.3

TABLE III- B.

SOUTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
LAURENS	92	96	0	757	0	0	1.7
Bailey Mem.			0	456	0	0	1.0
Whitten Village			0	2	0	0	0+
Laurens District			0	299	0	0	0.7
LEE	69	253	0	198	0	0	0.4
Lee Cnty. Mem.			0	198	0	0	0.4
LEXINGTON	84	105	0	0	0	0	0
MCCORMICK	77	75	0	0	0	0	0
MARION	78	201	8	633	12.6	1.2	1.4
Finger Clinic			2	154	13.0	0.3	0.3
Marion Cnty. Mem.			5	189	26.5	0.7	0.4
Martin			0	45	0	0	0.1
Mullins			1	245	4.1	0.1	0.5
MARLBORO	62	242	0	592	0	0	1.3
Marlboro Gen			0	592	0	0	1.3
NEWBERRY	91	237	0	394	0	0	0.9
Newberry Cnty. Mem.			0	394	0	0	0.9
OCONEE	99	61	3	946	3.2	0.4	2.1
Oconee Mem.			3	946	3.2	0.4	2.1
ORANGEBURG	82	175	1	1,235	0.8	0.1	2.8
Orangeburg Regional			1	1,235	0.8	0.1	2.8
PICKENS	94	81	0	1,046	0	0	2.3
Easley Baptist			0	800	0	0	1.8
Cannon Mem.			0	246	0	0	0.6

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TABLE III-B.

SOUTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
RICHLAND	72	130	19	4,448	4.3	2.8	10.0
Columbia			1	0	-	0.1	0
Good Samaritan Wav.			0	71	0	0	0.2
Providence			1	1,665	1.0	0.1	3.7
S.C. Baptist			17	2,694	6.3	2.5	6.0
S.C. State			0	18	0	0	0+
SALUDA	70	147	0	0	0	0	0
SPARTENBURG	88	126	7	3,088	2.3	1.0	6.9
Mary Black Mem.			0	676	0	0	1.5
Spartanburg Gen.			7	2,412	2.9	1.0	5.4
Woodruff Gen.			0	0	0	0	0
SUMTER	94	129	7	1,239	5.6	1.0	2.8
Tuomey			7	1,239	5.6	1.0	2.8
UNION	100	138	1	729	1.4	0.1	1.6
Hope			0	29	0	0	0.1
Wallace Thompson			1	700	1.4	0.1	1.6
WILLIAMSBURG	87	201	0	285	0	0	0.6
Willaimsburg Cnty. Mem.			0	285	0	0	0.6
YORK	86	163	7	1,893	3.7	1.0	4.2
York Gen.			7	1,591	4.4	1.0	3.6
Divine Saviour			0	302	0	0	0.7

TABLE III-C.

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	87	117	1,687	354,987	4.8		
ALAMANCE	93	93	17	6,924	2.4	1.0	1.9
Alamance Co			14	5,151	2.7	0.8	1.4
Mem. Hosp. of Alamance Co.			3	1,793	1.6	0.2	0.5
ALEXANDER	90	39	0	584	0	0	0.1
Alexander Co.			0	584	0	0	0.1
ALLEGHANY	97	33	0	476	0	0	0.1
Alleghany Co. Mem.			0	476	0	0	0.1
ANSON	90	217	0	762	0	0	0.2
Anson Co.			0	762	0	0	0.2
ASHE	96	63	0	1,047	0	0	0.3
Ashe Co. Mem.			0	1,047	0	0	0.3
AVERY	99	17	0	1,213	0	0	0.3
Chas. H. Cannon Jr. Mem.			0	735	0	0	0.2
Garrett Mem.			0	478	0	0	0.1
BEAUFORT	91	149	10	2,840	3.5	0.6	0.8
Pungo Dist.			6	477	12.5	0.4	0.1
Beaufort Co.			4	2,363	1.6	0.2	0.7
BERTIE	91	169	1	1,059	0.9	0.1	0.3
Bertie Co. Mem.			1	1,059	0.9	0.1	0.3
BLADEN	97	157	0	1,294	0	0	0.3
Bladen Co.			0	1,294	0	0	0.3

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TABLE III-C.

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
BRUNSWICK	87	197	0	560	0	0	0.1
J. Arthur Dosher Mem.			0	560	0	0	0.1
BUNCOMBE	89	94	45	11,014	4.0	2.7	3.1
Aston Park			1	0	--	0.1	0
Mem. Mission			44	5,443	8.0	2.6	1.5
St. Joseph's			0	5,571	0	0	1.6
BURKE	97	68	11	3,625	3.0	0.7	1.0
Grace			4	2,657	1.5	0.2	0.7
Valdese Gen'l.			7	968	7.2	0.4	0.3
CABARRUS	94	104	22	5,644	3.8	1.3	1.5
Cabarrus Mem.			22	5,644	3.8	1.3	1.5
CALDWELL	98	61	0	3,960	0	0	1.1
Caldwell Mem.			0	3,868	0	0	1.1
Blackwelder			0	0	0	0	0
Dula			0	92	0	0	0+
CAMDEN	91	159	0	0	0	0	0
CARTERET	77	117	4	538	7.4	0.2	0.1
Carteret Gen'l.			4	467	8.5	0.2	0.1
Sea Level			0	68	0	0	0+
CASWELL	89	128	0	0	0	0	0
CATAWBA	95	76	68	6,839	9.9	4.0	2.0
Catawba Mem.			30	1,809	16.5	1.8	0.5
Hickory Mem.			0	1,972	0	0	0.5
Richard Baker			38	3,058	12.4	2.3	0.9

TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CHATHAM	96	139	1	1,176	0.9	0.1	0.3
Mathiesen Clinic			0	316	0	0	0.1
Chatham			1	760	1.3	0.1	0.2
CHEROKEE	93	31	1	1,189	0.8	0.1	0.3
District Memorial Hospital of Southwestern N.C.			1	645	1.5	0.1	0.2
Providence			0	544	0	0	0.1
CHOWAN	80	184	3	1,200	2.5	0.2	0.3
Chowan			3	1,200	2.5	0.2	0.3
CLAY	93		0	0	0	0	0
CLEVELAND	95	123	48	7,282	6.5	2.8	2.0
Royster Memorial			0	452	0	0	0.1
Kings Mountain			1	2,245	0.4	0.2	0.6
Cleveland Memorial			47	4,585	10.2	2.8	1.3
COLUMBUS	92	18	0	2,077	0	0	0.6
Columbus County			0	2,077	0	0	0.6
CRAVEN	85	94	1	5,996	0.1	0.1	1.7
Craven County			1	5,996	0.1	0.1	1.7
CUMBERLAND	87	81	9	36,151	0.2	0.5	10.1
Cape Fear Valley			1	33,750	0+	0.1	9.5
Highsmigh - Rainy Memorial			8	1	--	0.5	0+
Veterans Administration			0	0	0	0	0
(other)			0	2,401	0	0	0.6

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CURRITUCK	89	145	0	0	0	0	0
DARE	97	33	0	0	0	0	0
DAVIDSON	100	73	1	4,154	0.2	0.1	1.1
Lexington Memorial			1	2,569	0.3	0.1	0.7
City Memorial			1	1,585	0	0	0.4
DAVIE	100	72	0	1,026	0	0	0.2
Davie County			0	1,026	0	0	0.2
DUPLIN	78	145	0	839	0	0	0.2
Duplin General			0	839	0	0	0.2
DURHAM	72	123	148	14,491	10.2	8.8	4.1
Duke University Medical Center			124	6,621	18.7	7.4	2.0
Lincoln			9	1,408	6.3	0.5	0.3
Veterans Administration			0	0	0	0	0
Watts			15	6,462	2.3	0.9	1.8
EDGECOMBE	80	271	8	2,120	1.5	0.5	0.6
Memorial			0	626	0	0	0.1
Edgecombe General			8	1,398	5.7	0.5	0.4
Quigless Clinic			0	96	0	0	0.1
FORSYTH	76	128	214	17,843	11.9	12.7	5.0
Casstevens			0	0	0	0	0
Forsyth Memorial			6	8,212	0.7	0.4	2.3
N. Carolina Baptist			206	7,091	29.0	12.2	2.0
Reynold Memorial			2	2,540	0.7	0.1	0.7
FRANKLIN	93	136	3	1,061	2.8	0.2	0.2
Franklin Memorial			3	1,061	2.8	0.2	0.2

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
GASTON	92	71	0	9,701	0	0	2.7
Garrison General			0	1,809	0	0	0.5
Gaston Memorial			0	7,892	0	0	2.2
GATES	74	178	0	0	0	0	0
GRAHAM	100	29	0	0	0	0	0
GRANVILLE	97	121	14	0	--	0.8	0
GREENE	83	194	0	0	0	0	0
GUILFORD	92	109	129	22,377	5.7	7.6	6.3
L. Richardson Memorial			0	2,031	0	0	0.5
Moses H. Cone Memorial			117	5,347	21.8	6.9	1.5
Wesley Long Community			0	7,136	0	0	2.0
Highpoint Memorial			12	7,863	1.5	0.7	2.2
HALIFAX	87	239	0	694	0	0	0.2
Roanoke Rapids			0	694	0	0	0.2
Oar Community			0	0	0	0	0
HARNETT	92	161	0	2,303	0	0	0.6
Good Hope			0	923	0	0	0.2
Betsy Johnson Memorial			0	1,380	0	0	0.4
HAYWOOD	98	48	4	2,801	1.4	0.2	0.7
Haywood County			4	2,801	1.4	0.2	0.7
HENDERSON	100	43	3	3,117	0.9	0.2	0.8
Valley Clinic			0	144	0	0	0
Mountain Sanitarium and Hospital			0	287	0	0	0.1
Margaret R. Pardee Memorial			3	2,688	1.1	0.2	0.7

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
HERTFORD	91	226	5	2,075	2.4	0.3	0.6
Roanoke-Chowan			5	2,075	2.4	0.3	0.6
HOKE	91	277	0	0	0	0	0
HYDE	90	294	0	0	0	0	0
IREDELL	96	128	12	6,413	1.8	0.7	1.8
Lawrance			8	1,921	4.1	0 5	0.5
Davis			0	1,851	0	0	0.5
Iredell Memorial			4	2,641	1.5	0.2	0.7
JACKSON	100	75	6	373	16.0	0.4	0.1
C.J. Harris Community			6	373	16.0	0.4	0.1
JOHNSTON	95	129	0	800	0	0	0.2
Johnston Memorial			0	800	0	0	0.2
JONES	61	149	0	0	0	0	0
LEE	81	137	0	723	0	0	0.2
Lee County			0	723	0	0	0.2
LINCOLN	89	157	1	4,537	0.2	0.1	1.2
[illegible] Memorial			1	4,151	0.2	0.1	1.2
[illegible] Memorial			0	386	0	0	0.1
[illegible]	93	73	0	990	0	0	0.2
[illegible] Memorial			0	990	0	0	0.2
[illegible]	98	33	0	1,375	0	0	0.3
[illegible]			0	1,375	0	0	0.3
[illegible]	99	57	1	556	1.7	0.1	0.1
[illegible]			1	408	2.4	0.1	0.1
[illegible]			0	148	0	0	0+

TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970 (cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
MADISON	93	55	0	0	0	0	0
MARTIN	83	264	1	531	1.8	0.1	0.1
Robersonville Township			0	67	0	0	0+
Martin General			1	464	2.1	0.1	0.1
MECKLENBURG	21	138	179	27,087	6.6	10.6	7.6
Charlotte Memorial			179	13,529	13.2	10.6	3.8
Presbyterian			0	1,757	0	0	2.7
Mercy			0	2,801	0	0	1.1
MITCHELL	98	53	1	991	1.0	0.1	0.2
Spruce Pine Community			1	991	1.0	0.1	0.2
MONTGOMERY	85	145	2	1,351	1.4	0.1	0.3
Montgomery Memorial			2	1,351	1.4	0.1	0.3
MOORE	93	126	17	3,541	4.8	1.0	1.0
Moore Memorial			17	3,493	4.8	1.0	1.0
St. Joseph of the Pines			0	48	0	0	0+
NASH	85	196	22	4,191	5.2	1.3	1.1
Parkview			20	3,033	6.5	1.2	0.8
Rocky Mountain Sanitarium			2	1,158	1.7	0.1	0.3
NEW HANOVER	93	149	0	5,164	0	0	1.4
Cape Fear Memorial			0	955	0	0	0.2
New Hanover Memorial		0	0	4,209	0	0	1.2
NORTH HAMPTON	84	237	0	0	0	0	0
ONSLOW	96	48	10	9,566	1.0	0.6	2.6
Onslow Memorial			5	2,308	2.1	0.3	0.6
(other)			5	7,258	0.6	0.3	2.0

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
ORANGE	78	76	558	4,417	126.3	33.1	1.2
N. Carolina Memorial			558	4,417	126.3	33.1	1.2
PAMLICO	87	183	0	0	0	0	0
PASQUOTANK	92	93	0	2,838	0	0	0.7
Albemarle			0	2,838	0	0	0.7
PENDER	93	214	0	1,106	0	0	0.3
Pender Memorial			0	1,106	0	0	0.3
PERQUIMANS	81	162	0	0	0	0	0
PERSON	78		0	1,780	0	0	0.5
Person County Memorial			0	1,780	0	0	0.5
PITT	93	120	8	4,650	1.7	0.5	1.3
Pitt County Memorial			8	4,650	1.7	0.5	1.3
POLK	100	181	0	916	0	0	0.2
St. Lukes			0	916	0	0	0.2
RANDOLPH	100	63	19	2,882	6.5	1.1	0.8
Randolph			19	2,882	6.5	1.1	0.8
RICHMOND	99	147	3	2,420	1.2	0.2	0.6
Hamlet			0	214	0	0	0.1
Richmond Memorial			3	2,206	1.3	0.2	0.6
ROBESON	93	173	66	7,244	9.1	3.9	2.0
Southeastern General			66	7,244	9.1	3.9	2.0
ROCKINGHAM	91	103	7	5,904	1.1	0.4	1.6
Morehead Memorial			0	2,746	0	0	0.7
Annie Penn Memorial			7	3,158	2.2	0.4	0.8

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
ROWAN	91	83	10	4,706	2.1	0.6	1.3
Rowan Memorial			10	4,706	2.1	0.6	1.3
RUTHERFORD	93	109	0	793	0	0	0.2
Rutherford			0	793	0	0	0.2
SAMPSON	98	128	1	2,225	0.4	0.1	0.6
Sampson County Memorial			1	2,225	0.4	0.1	0.6
SCOTLAND	85	222	6	4,088	1.4	0.4	1.1
Scotland Memorial			6	4,088	1.4	0.4	1.1
STANLY	97	96	3	2,653	1.1	0.2	0.7
Stanly County			3	2,653	1.1	0.2	0.7
STOKES	100	36	0	45	0	0	0+
Stokes-Reynolds Memorial			0	45	0	0	0+
SURRY	92	41	0	4,537	0	0	1.2
Hugh Chatham Memorial			0	1,440	0	0	0.4
Northern Hospital of Surry County			0	3,097	0	0	0.8
SWAIN	150	155	1	1,035	0.9	0.1	0.3
Swain County			1	721	1.3	0.1	0.2
U.S. Public Health Service Indian			0	314	0	0	0.1
TRANSYLVANIA	94	74	1	1,083	0.9	0.1	0.3
Transylvania Community			1	1,083	0.9	0.1	0.3
TYRELL	29	182	0	0	0	0	0

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970 (cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
UNION	93	92	1	3,903	0.2	0.1	1.0
Union Memorial			1	3,903	0.2	0.1	1.0
VANCE	91	159	4	2,426	1.6	0.2	0.6
Maria-Parham			4	2,426	1.6	0.2	0.6
WAKE	95	109	28	15,730	1.7	1.7	4.4
Fuquay-Varina Branch of Wake County Hospitals			0	121	0	0	0+
Mary Elizabeth			0	0	0	0	0
Wake Memorial			4	5,761	0.7	0.2	1.6
Rex			24	9,848	2.4	1.4	2.7
WARREN	74	157	0	18	0	0	0+
Warren General			0	18	0	0	0+
WASHINGTON	83	218	0	103	0	0	0+
Washington County			0	103	0	0	0+
WATUGA	96	7	0	476	0	0	0.1
Watuga County			0	476	0	0	0.1
Blowing Rock			0	0	0	0	0
WAYNE	83	124	15	3,266	4.5	0.9	0.9
Wayne County			15	3,250	4.5	0.9	0.9
(other)			0	16	0	0	0+
WILKES	98	60	0	2,944	0	0	0.8
Wilkes General			0	2,944	0	0	0.8
WILSON	98	188	14	4,358	3.2	0.8	1.2
Wilson Memorial			14	4,358	3.2	0.8	1.2
YADKIN	98	34	1	653	1.5	0.1	0.1

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TABLE III-C

NORTH CAROLINA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967 - 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967 - 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
Lula Conrad Hoots Memorial			1	653	1.5	0.1	0.1
YANCEY	95	28	0	539	0	0	0.1
Yancey			0	539	0	0	0.1

TABLE III-D

VIRGINIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	96	105	2,214	64,787	34.1		
ACCOMACK	100	319	0	0	0	0	0
ALBEMARLE	74	82	155	2,361	65.6	7.0	3.6
ALLEGHANY	100	58	0	584	0	0	1.0
AMELIA	100	217	0	0	0	0	0
AMHERST	100	117	0	10	0	0	0+
APPOMATTOX	100	103	0	0	0	0	0
ARLINGTON	100	72	388	4,413	87.9	17.6	7.0
AUGUSTA	100	75	0	1,256	0	0	2.0
BATH	100	22	0	0	0	0	0
BEDFORD	100	118	0	262	0	0	0.4
BLAND	100	23	0	0	0	0	0
BOTETOURT	100	78	0	0	0	0	0
BRUNSWICK	100	212	0	0	0	0	0
BUCHANAN	100	61	0	451	0	0	0.7
BUCKINGHAM	100	183	0	0	0	0	0
CAMPBELL	100	96	0	2,274	0	0	3.5
CAROLINE	100	160	0	0	0	0	0
CARROLL	100	41	0	0	0	0	0
CHARLES CITY	100	143	0	0	0	0	0

TABLE III-D

VIRGINIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CHARLOTTE	100	180	0	0	0	0	0
CHESAPEAKE CITY			0	0	0	0	0
CHESTERFIELD	100	48	0	0	0	0	0
CLARKE	100	127	0	0	0	0	0
CRAIG	100	-	0	0	0	0	0
CULPEPER	100	109	0	314	0	0	0.5
CUMBERLAND	100	267	0	0	0	0	0
DICKENSON	100	53	0	0	0	0	0
DINWIDDIE	100	218	0	1,136	0	0	1.8
ESSEX	100	117	0	87	0	0	0.1
FAIRFAX	100	38	600	4,886	122.7	27.1	7.5
FAUQUIER	100	115	8	436	18.3	0.4	0.7
FLOYD	100	42	0	0	0	0	0
FLUVANNA	100	241	0	0	0	0	0
FRANKLIN	100	69	0	317	0	0	0.5
FREDERICK	100	71	20	1,628	12.3	0.9	2.6
GILES	100	85	0	273	0	0	0.4
GLOUCESTER	100	93	0	0	0	0	0
GOOCHLAND	100	244	0	0	0	0	0
GRAYSON	100	71	0	502	0	0	0.8
GREENE	100	173	0	0	0	0	0
GREENSVILLE	100	235	0	300	0	0	0.5
HALIFAX	100	122	42	738	56.9	1.9	1.1

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TABLE III-D

VIRGINIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
HANOVER	100	107	0	0	0	0	0
HENRICO	43	158	0	0	0	0	0
HENRY	100	98	2	1,205	1.7	0.1	1.9
HIGHLAND	100	91	0	0	0	0	0
ISLE OF WIGHT	100	225	0	0	0	0	0
JAMES CITY	100	202	0	338	0	0	0.5
KING AND QUEEN	100	140	0	0	0	0	0
KING GEORGE	100	182	0	0	0	0	0
KING WILLIAM	100	172	0	0	0	0	0
LANCASTER	100	247	0	0	0	0	0
LEE	100	56	0	185	0	0	0.3
LOUDOUN	100	105	0	508	0	0	0.8
LOUISA	100	220	0	0	0	0	0
LUNENBURG	100	87	0	0	0	0	0
MADISON	100	113	0	0	0	0	0
MATHEWS	100	108	0	0	0	0	0
MECKLENBURG	100	170	2	0	-	0.1	0
MIDDLESEX	100	95	0	0	0	0	0
MONTGOMERY	100	61	0	30	0	0	0+
NANSEMOND	100	224	0	824	0	0	1.3
NELSON	100	86	0	0	0	0	0
NEW KENT	100	152	0	0	0	0	0

TABLE III-D

VIRGINIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970 (cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
NORFOLK	84	140	196	6,722	29.2	8.8	11.3
NORTHAMPTON	100	363	12	339	35.3	0.5	0.5
NORTHUMBERLAND	100	233	0	0	0	0	0
NOTTOWAY	100	226	0	0	0	0	0
ORANGE	100	120	0	0	0	0	0
PAGE	100	78	0	73	0	0	0.1
PATRICK	100	49	0	252	0	0	0.4
PITTSYLVANIA	100	129	6	1,619	3.7	0.3	2.5
POWHATAN	100	102	0	0	0	0	0
PRINCESS ANNE	-	-	10	897	1.1	0.5	1.4
PRINCE EDWARD	100	177	0	732	0	0	1.1
PRINCE GEORGE	100	75	0	259	0	0	0.4
PRINCE WILLIAM	100	31	2	896	2.2	0.1	1.4
PULASKI	100	53	0	1,897	0	0	2.9
RAPPAHANNOCK	100	106	0	0	0	0	0
RICHMOND	100	133	574	11,005	52.2	25.9	17.0
ROANOKE	100	95	132	3,289	40.1	6.0	5.1
ROCKBRIDGE	100	97	0	412	0	0	0.6
ROCKINGHAM	100	75	2	1,187	1.7	0.1	1.8
RUSSELL	100	70	0	0	0	0	0
SCOTT	100	15	0	0	0	0	0
SHENANDOAH	100	57	0	197	0	0	0.3

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TABLE III-D

VIRGINIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
SMYTH	100	34	4	519	7.7	0.2	0.8
SOUTHAMPTON	100	264	0	0	0	0	0
SPOTSYLVANIA	100	106	2	1,406	1.4	0.1	2.2
STAFFORD	100	56	0	0	0	0	0
SURRY	100	260	0	0	0	0	0
SUSSEX	100	236	0	0	0	0	0
TAZEWELL	100	72	0	928	0	0	1.4
WARREN	100	94	0	333	0	0	0.5
WASHINGTON	100	59	4	492	8.1	0.2	0.8
WESTMORELAND	100	265	0	0	0	0	0
WISE	100	51	0	679	0	0	1.0
WYTHE	100	52	0	172	0	0	0.3
YORK	100	104	24	3,992	6.0	1.1	6.2

TABLE III-E

MARYLAND: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1969-1970

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1969-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	66	--	7,667	111,290	68.9		
ALLEGANY	93		13	2,982	0	0	2.7
Mem.			13	1,860	0	1.7	1.7
Miners			0	172	0	0	0.2
Sac. Heart			0	950	0	0	0.9
ANNE ARUNDEL	72		170	2,806	60.6	2.2	2.5
Anne Arundel Gen.			170	2,736	62.1	2.2	2.5
No. Arundel			0	70	0	0	0.1
BALTIMORE	44		266	10,300	25.8	3.5	9.3
Greater Balt. Med.			266	5,162	51.5	3.5	4.6
St. Joseph			0	5,138	0	0	4.6
BALTIMORE CITY			6,592	53,246	123.8	86.0	47.8
Balt. City			468	9,786	47.8	6.1	8.8
Bon Secours			0	2,214	0	0	2.0
Church Home			478	2,612	183.0	6.2	2.3
Franklin Sq.			178	960	185.4	2.3	0.9
John Hopkins			2,808	4,572	614.1	36.6	4.1
Lutheran			475	2,608	182.1	6.2	2.3
Md.Gen.			323	2,584	125.0	4.2	2.3
Mercy			0	2,944	0	0	2.6
Provident			272	880	309.1	3.5	0.8
St. Agnes			0	5,742	0	0	5.2
Sinai			1,307	8,450	154.7	17.0	7.6
Sc. Balt. Gen.			80	2,072	38.6	1.0	1.9
Union Mem.			88	2,910	30.2	1.1	2.6
Univ. of Md.			115	4,912	23.4	1.5	4.4
CALVERT	72		2	482	4.1	0+	0.4
Calvert County NA	72		2	482	4.1	0+	0.4

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TABLE.III-E

MARYLAND: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1969-1970

(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1969-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CAROLINE	78	--	0	0	0	0	0
CARROLL	89		3	1,420	2.1	0+	1.3
Carroll Cty. Gen.			3	1,420	2.1	0+	1.3
CECIL	86		0	1,374	0	0	1.2
Union	86		0	1,374	0	0	1.2
CHARLES	88		0	1,018	0	0	0.9
Physicians Mem.	88		0	1,018	0	0	0.9
DORCHESTER	87		14	866	16.1	0.2	0.8
Cambridge	87		14	866	16.1	0.2	0.8
FREDERICK	85		8	2,228	3.6	0.1	2.0
Frederick Mem.	85		8	2,228	3.6	0.1	2.0
GARRETT	98		0	714	0	0	0.6
Garrett Mem.	98		0	714	0	0	0.6
HARFORD	80		1	2,216	0+	0+	2.0
Harford Mem.	80		1	2,216	0+	0+	2.0
HOWARD	69		0	0	0	0	0
KENT	70		3	650	4.6	0+	0.6
Kent & Queen Ann.	70		3	650	4.6	0+	0.6

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Table III-E

MARYLAND: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1969-1970 (cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1969-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
MONTGOMERY	79		401	13,634	29.4	5.2	12.3
Holy Cross Hosp. of Silver Spg.			0	7,374	0	0	6.6
Montgomery Gn. Hosp.			10	742	13.5	0.1	0.7
Suburban Hosp. Ass'n.			342	3,222	106.1	4.5	2.9
Washington San. & Hosp.			49	2,296	21.3	0.6	2.0
PRINCE GEORGES	86		10	8,176	1.2	0.1	7.3
Prince Geo. Gen.			10	8,176	1.2	0.1	7.3
Eugene Leland Mem.			0	0	0	0	0
Clinton Mem. NA			0	0	0	0	0
QUEEN ANNES	76		0	0	0	0	0
ST. MARYS	80		2	1,280	1.6	0+	1.1
St. Marys Hosp. NA			2	1,280	1.6	0+	1.1
SOMERSET	91		0	224	0	0	0.2
Edw. W. McCready's Mem.			0	224	0	0	0.2
TALBOT	87		30	1,540	19.5	0.4	1.4
Memorial			30	1,540	19.5	0.4	1.4
WASHINGTON	89		14	3,440	4.1	0.2	3.1
Washington Cnty.			14	3,440	4.1	0.2	3.1
WICOMICO	75		138	3,176	43.4	1.8	2.9
Peninsula Gen.			138	3,176	43.4	1.8	2.9
WORCHESTER	71		0	0	0	0	0

TABLE III-F

DELAWARE: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	63	122	558	9,287	60.1		
KENT	86	94	20	816	24.5	3.6	8.8
Kent Gen.			20	816	24.5	3.6	8.8
NEWCASTLE	46	116	525	6,878	76.3	94.1	74.1
Riverside Osteo.			3	100	30	0.5	1.1
St. Francis			0	634	0	0	6.8
Wilmington Med. Ctr.			522	6,144	85.0	93.5	66.2
SUSSEX	80	177	13	1,593	8.2	2.3	17.2
Beebe			2	373	5.4	0.4	4.0
Milford Mem.			7	743	9.4	1.3	8.0
Nanticoke			4	477	8.4	0.7	5.1

TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	71	--	3,900	140,664	27.7		
ADAMS	68		1	598	1.7	0+	0.4
Brighton Comm.			1	598	1.7	0+	0.4
ALAMOSA	100		0	1,244	0	0	0.9
Alamosa Comm.			0	1,244	0	0	0.9
ARAPAHOE	85		135	8,025	16.8	3.5	5.7
Swedish Hos.			135	8,025	16.8	3.5	5.7
ARCHULETTA	96		0	0	0	0	0
BACA	100		0	0	0	0	0
BENT	96		0	0	0	0	0
BOULDER	88		693	7,687	90.2	17.8	5.5
Boulder Comm.			655	3,895	168.2	16.7	2.8
Boulder Mem.			20	1,778	11.2	0.5	1.3
Longmont Comm.			18	2,004	9.2	0.5	1.4
Longs Peak Osteo. Comm. NA			0	0	0	0	0
CHAFFEE	100		0	767	0	0	0.5
Salida NA			0	767	0	0	0.5
CHEYENNE	100		0	230	0	0	0.2
St. Jos. of the Plains			0	230	0	0	0.2
CLEAR CREEK	100		0	0	0	0	0

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TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970 (cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 19				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
CONEJOS	77		0	599	0	0	0.4
Conejos County			0	599	0	0	0.4
COSTILLA	90		0	0	0	0	0
CROWLEY	100		0	0	0	0	0
CUSTER	100		0	0	0	0	0
DELTA	100		0	745	0	0	0.5
Delta Memorial NA			0	745	0	0	0.5
DENVER	8		2,676	74,307	36.0	68.6	52.8
Beth Israel			603	6,550	92.1	15.5	4.7
Colorado Gen.			314	7,835	40.1	8.1	5.6
Denver Gen.			525	6,279	85.2	13.7	4.5
Fitzsimmons			58	2,492	23.3	1.5	1.8
General Rose			956	11,258	84.9	24.5	8.0
Porter			69	3,736	18.5	1.8	2.1
Presbyterian			83	3,660	22.7	2.1	2.6
Mercy			0	4,070	0	0	2.9
Rocky Mountains Osteo. NA			0	1,384	0	0	1.0
St. Anthony			0	8,154	0	0	5.8
St. Joseph			0	10,570	0	0	7.5
St. Lukes			58	5,547	10.5	1.5	3.9
Valley View NA			0	674	0	0	0.5
(Other)			0	2,098	0	0	1.5
DOLORES	100		0	0	0	0	0
DOUGLAS	100		0	0	0	0	0
EAGLE	23		0	0	0	0	0
ELBERT	100		0	0	0	0	0
EL PASO	90		154	9,654	16.0	3.9	6.8
Mamie Eisenhower Osto. NA			0	264	0	0	0.2
Memorial- Colo.Spgs.			154	2,418	63.7	3.9	1.7
Penrose			0	4,506	0	0	3.2
St. Francis			0	2,466	0	0	1.8

TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970 (cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
FREMONT	100		0	979	0	0	0.7
St. Thomas More			0	669	0	0	0.5
St. Joseph			0	310	0	0	0.2
GARFIELD	100		4	1,137	3.5	0.1	0.8
Valley View			4	898	4.5	0.1	0.6
Clagett Mem.			0	239	0	0	0.2
GILPIN	100		0	0	0	0	0
GRAND	100		0	0	0	0	0
GUNNISON	100		0	433	0	0	0.3
Gunnison County NA			0	433	0	0	0.3
HINSDALE	100		0	0	0	0	0
HUERFANO	82		0	0	0	0	0
Huerfano Mem.			0	0	0	0	0
JACKSON	100		0	0	0	0	0
JEFFERSON	100		151	3,495	43.2	3.9	2.5
Lutheran			151	3,495	43.2	3.9	2.5
KIOWA	100		0	0	0	0	0
KIT CARSON	100		0	533	0	0	0.4
Kit Carson Mem. NA			0	533	0	0	0.4
LAKE	100		0	864	0	0	0.6
St. Vincent			0	864	0	0	0.6
LA PLATA	90		0	1,365	0	0	1.0
La Plata County NA			0	362	0	0	0.3
Mercy			0	1,003	0	0	0.7

TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970 (cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
LARIMER	95		43	2,868	14.9	1.1	2.0
Poudre Valley			42	2,194	19.1	1.0	1.6
Loveland Mem.			1	674	1.5	0 +	0.5
LAS ANIMAS	73		0	155	0	0	0.1
Mt. San Rafael NA			0	155	0	0	0.1
LINCOLN	100		0	0	0	0	0
LOGAN	100		1	1,165	0.9	0 +	0.8
Logan County			1	1,165	0.9	0 +	0.8
MESA	98		0	3,174	0	0	2.3
Plateau Valley NA			0	24	0	0	0 +
Lower Valley NA			0	189	0	0	0.1
Grand Junction NA			0	552	0	0	0.4
Mesa Memorial NA			0	248	0	0	0.2
St. Mary's			0	2,227	0	0	1.6
MINERAL	100		0	0	0	0	0
MOFFAT	100		0	851	0	0	0.6
Memorial			0	851	0	0	0.6
MONTEZUMA	100		0	1,158	0	0	0.8
Southwest Memorial			0	1,158	0	0	0.8
MONTROSE	100		9	1,013	8.9	0.2	0.7
Montrose Memorial			9	1,013	8.9	0.2	0.7
MORGAN	100		0	750	0	0	0.5
East Morgan NA			0	228	0	0	0.2
Fort Morgan Comm.			0	522	0	0	0.4

TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970 (cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
OTERO	100		1	2,097	0.5	0 +	1.5
La Junta Med. Ctr.			0	1,291	0	0	0.9
Pioneers Mem.			1	806	1.2	0 +	0.6
OURAY	100		0	0	0	0	0
PARK	100		0	62	0	0	0 +
Park County NA			0	62	0	0	0 +
PHILLIPS	100		0	274	0	0	0.2
Haxtun NA			0	71	0	0	0.1
Melissa NA			0	203	0	0	0.1
PITKIN	100		0	288	0	0	0.2
Aspen Valley NA			0	288	0	0	0.2
PROWERS	100		0	1,049	0	0	0.7
Prowers Med. Ctr. NA			0	1,049	0	0	0.7
PUEBLO	80		19	6,323	3.0	0.5	4.5
Parkview Episc.			19	2,165	8.8	0.5	1.5
St. Mary Corwin			0	4,158	0	0	3.0
RIO BLANCO	100		0	386	0	0	0.3
Pioneers NA			0	251	0	0	0.2
Rangely NA			0	135	0	0	0.1
RIO GRANDE	87		0	964	0	0	0.7
St. Joseph NA			0	403	0	0	0.3
Monte Vista NA			0	426	0	0	0.3
ROUTT	100		0	229	0	0	0.2
Routt County Mem. NA			0	229	0	0	0.2

TABLE III-G

COLORADO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1967-1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1967-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
SAGUACHE	64		0	0	0	0	0
SAN JUAN	100		0	0	0	0	0
SAN MIGUEL	100		0	0	0	0	0
SEDGWICK	100		1	237	4.2	0 +	0.2
Sedgwick County	NA		1	237	4.2	0 +	0.2
SUMMIT	100		0	0	0	0	0
TELLER	100		0	0	0	0	0
WASHINGTON	100		0	96	0	0	0.1
Washington Pub.	NA		0	96	0	0	0.1
WELD	84		12	4,522	2.7	0.3	3.2
Weld County			12	1,094	11.0	0.3	0.8
Memorial	NA		0	3,428	0	0	2.4
YUMA	100		0	476	0	0	0.3
Wray Comm.	NA		0	238	0	0	0.2
Yuma	NA		0	238	0	0	0.2

TABLE III-H

NEW MEXICO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	70.8	--	1,300	17,264	75.3		
BERNALILLO	71		1,041	5,942	175.2	80.1	34.4
A.T. & S.F.			0	0	0	0	0
Bataan Mem.			74	524	141.2	5.7	3.0
Bernalillo Cnty. Med.			0	1,260	0	0	7.3
Doctors Hosp. Ass'n.			48	0	-	3.7	0
Osteopathic			7	718	9.7	0.5	4.2
Presbyterian			912	2,522	361.6	70.2	14.6
St. Joseph			0	918	0	0	5.3
CATRON	100		0	0	0	0	0
CHAVES	77		80	769	104	6.2	4.5
Eastern N. Mex. Med.			72	639	112.7	5.5	3.7
Memorial Osteo.			8	130	61.5	0.6	0.8
St. Marys			0	0	0	0	0
COLFAX	100		0	243	0	0	1.4
Miner's			0	208	0	0	1.2
Colfax Gen.			0	35	0	0	0.2
CURRY	95		0	627	0	0	3.6
Clovis Mem.			0	627	0	0	3.6
DEBACA	100		0	0	0	0	0
DONA ANA	86		34	1,157	29.4	2.6	6.7
Memorial Gen.			34	1,157	29.4	2.6	6.7
EDDY	90		18	306	58.8	1.4	1.8
Artesia Gen.			6	306	19.6	0.5	1.8
Carlsbad Regional Med. Ctr.			12	0	-	0.9	0
GRANT	100		0	515	0	0	3.0
Hillcrest Gen.			0	515	0	0	3.0

TABLE III-H

NEW MEXICO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
GUADALUPE	100		0	59	0	0	0.3
Guadalupe Gen.			0	59	0	0	0.3
HARDING	100		0	0	0	0	0
HIDALGO	100		2	71	28.2	0.2	0.4
Hidalgo Gen.			2	71	28.2	0.2	0.4
LEA	100		6	851	7.1	0.5	4.9
Hobbs Lea Gen.			0	590	0	0	3.4
Lovington Lea Gen.			6	219	27.4	0.5	1.3
(Other)			-	42	-	-	0.2
LINCOLN	100		0	117	0	0	0.7
Ruidoso-Hondo Val. Gen.			0	103	0	0	0.6
(Other)			-	14	-	-	0.1
LOS ALAMOS	100		42	211	199.1	3.2	1.2
Los Alamos Med.			42	211	199.1	3.2	1.2
LUNA	100		0	304	0	0	1.8
Mimbres Mem.			0	304	0	0	1.8
MCKINLEY	75		27	1,443	18.7	2.1	8.4
Gallup Indian Med. Ctr.			27	732	36.9	2.1	4.2
McKinley Gen. NA			0	226	0	0	1.3
Rehoboth Christian NA			0	113	0	0	0.7
(Other)			-	372	-	-	2.2
MORA	100		0	0	0	0	0
OTERO	96		0	445	0	0	2.6
Gerald Champion Mem.			0	390	0	0	2.3
(Other)			-	65	-	-	0.4

TABLE III-H

NEW MEXICO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970 (cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
QUAY	92		0	179	0	0	1.0
Trigg Mem.			0	179	0	0	1.0
RIO ARRIBA	93		0	524	0	0	3.0
Embudo Presby.			0	234	0	0	1.4
Espanola			0	290	0	0	1.7
ROOSEVELT	96		0	172	0	0	1.0
Roosevelt Gen.			0	172	0	0	1.0
SANDOVAL	98		0	0	0	0	0
SAN JUAN	74		10	1,125	8.9	0.8	6.5
Navajo			10	524	19.1	0.8	3.0
San Juan			0	601	0	0	3.5
SAN MIGUEL	42		0	474	0	0	2.8
Las Vegas			0	266	0	0	1.5
Las Vegas Med. Cntr.	NA		0	0	0	0	0
St. Anthony's			0	208	0	0	1.2
SANTA FE	88		0	1,132	0	0	6.6
St. Vincent			0	970	0	0	5.6
(Other)			-	162	-	-	0.9
SIERRA	100		0	39	0	0	0.2
St. Ann's	NA		0	39	0	0	0.2
SOCORRO	100		0	179	0	0	1.0
Socorro Gen.			0	179	0	0	1.0
TAOS	93		40	126	317.5	3.1	0.7
Holy Cross			40	126	317.5	3.1	0.7

TABLE III-H

NEW MEXICO: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY AND MEDICAL FACILITY, 1970
(cont.)

COUNTY Hospital	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
TORRANCE	98		0	0	0	0	0
UNION	98		0	53	0	0	0.3
Union City Gen.			0	53	0	0	0.3
VALENCIA	100		0	191	0	0	1.1
Cibola Gen.			0	191	0	0	1.1

TABLE III-I.

OREGON: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1969-1970

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1969-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	93	66	8,603	68,764	125.1		
BAKER	100	14	0	366	0	0	0.5
BENTON	100	44	83	1,810	45.8	1.0	2.6
CLACKAMAS	94	49	43	1,196	40.0	0.5	1.7
CLATSOP	75	42	6	904	6.6	0.1	1.3
COLUMBIA	100	25	7	400	17.5	0.1	0.6
COOS	100	62	50	868	57.6	0.6	1.3
CROOK	100	53	13	314	41.4	0.2	0.5
CURRY	100	18	0	0	0	0	0
DESCHUTES	100	66	56	656	85.4	0.7	1.0
DOUGLAS	93	41	58	2,280	25.4	0.7	3.3
GILLIAM	100	45	0	0	0	0	0
GRANT	100	--	0	230	0	0	0.3
HARNEY	100	31	6	0	--	0.1	0
HOOD RIVER	100	23	5	382	13.1	0.1	0.6
JACKSON	100	35	280	4,146	67.5	3.3	6.0
JEFFERSON	100	78	5	244	20.5	0.1	0.3
JOSEPHINE	100	43	23	1,030	22.3	0.3	1.5
KLAMATH	100	39	4	1,832	2.2	0.1	2.7
LAKE	100	23	0	1,062	0	0	1.5
LANE	100	58	655	9,616	68.1	7.6	14.0

TABLE III-I.

OREGON: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1969-1970

(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1969-1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
LINCOLN	100	79	9	216	41.7	0.1	0.3
LINN	100	41	9	1,078	8.3	0.1	1.6
MALHEUR	100	34	9	1,750	5.1	0.1	2.5
MARION	100	62	102	6,458	15.8	1.2	9.4
MORROW	100	--	0	448	0	0	0.6
MULTNOMAH	79	110	6,904	25,728	268.3	80.3	37.4
POLK	86	77	28	308	90.9	0.3	0.4
SHERMAN	100	--	0	0	0	0	0
TILLAMOOK	100	69	12	466	25.8	0.1	0.7
UMATILLA	91	60	50	2,064	24.2	0.6	3.0
UNION	100	57	29	666	43.5	0.3	1.0
WALLOWA	100	38	1	144	6.9	0.1	0.2
WASCO	100	70	47	812	57.9	0.5	1.2
WASHINGTON	96	49	106	1,290	82.2	1.2	1.9
WHEELER	100	--	0	0	0	0	0
YAMHILL	96	36	3	0	--	0.1	0

TABLE III-J

CALIFORNIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
STATE TOTALS	80	--	62,672	322,464	194.2		
ALAMEDA	59		5,271	18,353	287.2	8.4	5.7
ALPINE	29		0	0	0	0	0
AMADOR	97		0	120	0	0	0+
BUTTE	94		46	946	48.6	0.1	0.3
CALAVERAS	100		2	103	19.4	0+	0+
COLUSA	99		2	158	12.7	0+	0+
CONTRA COSTA	82		1,175	6,474	181.5	1.9	2.0
DEL NORTE	99		0	273	0	0	0.1
EL DORADO	86		46	543	84.7	0.1	0.2
FRESNO	83		568	7,427	76.5	0.9	2.3
GLENN	99		0	264	0	0	0.1
HUMBOLDT	100		59	1,342	44	0.1	0.4
IMPERIAL	100		39	1,512	25.8	0.1	0.5
INYO	93		11	286	38.5	0+	0.1
KERN	86		355	5,307	66.9	0.6	1.6
KINGS	98		7	1,477	4.7	0+	0.5
LAKE	100		0	123	0	0	0+
LASSEN	100		8	0	-	0+	0
LOS ANGELES	74		25,993	122,852	211.6	41.5	38.1
MADERA	83		0	593	0	0	0.2

TABLE III-J

CALIFORNIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY, 1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	Births
MARIN	67		472	1,626	290.3	0.8	0.5
MARIPOSA	100		0	52	0	0	0+
MENDOCINO	97		2	650	3.1	0+	0.2
MERCED	82		23	1,377	16.7	0+	0.4
MODOC	100		0	79	0	0	0+
MONO	100		0	0	0	0	0
MONTEREY	100		565	3,356	168.4	0.9	1.0
NAPA	97		0	803	0	0	0.2
NEVADA	69		2	372	5.4	0+	0.1
ORANGE	88		1,672	24,941	67.0	2.7	7.7
PLACER	63		41	1,135	36.1	0.1	0.4
PLUMAS	100		14	150	93.3	0+	0+
RIVERSIDE	97		831	7,195	115.5	1.3	2.2
SACRAMENTO	91		3,420	10,204	335.2	5.5	3.1
SAN BENITO	68		2	0	-	0+	0
SAN BERNARDINO	96		668	11,497	58.1	1.1	3.5
SAN DIEGO	92		4,434	17,920	247.4	7.1	5.4
SAN FRANCISCO	29		6,413	14,407	445.1	10.2	4.4
SAN JOAQUIN	97		441	5,963	74	0.7	1.8
SAN LUIS OBISPO	79		529	627	843.7	0.8	0.2
SAN MATEO	72		1,180	6,159	191.6	1.9	1.9
SANTA BARBARA	43		984	2,524	389.9	1.6	0.8

TABLE III-J

CALIFORNIA: THERAPEUTIC ABORTION DISTRIBUTION - BY COUNTY,1970
(cont.)

COUNTY	Unmet Family Planning Needs, 1968		Number of Therapeutic Abortions, Births, and Abortions per 1000 Births, (T.A. Ratio), 1970				
	% Wom. w/o Fam. Plan. Program	Illeg. Bths./ 1000	# of T.A.'s	# of Births	T.A. Ratio	% State's: T.A.'s	% State's: Births
SANTA CLARA	92		5,737	20,716	276.9	9.2	6.3
SANTA CRUZ	90		2	559	3.6	0+	0.2
SHASTA	100		24	2,130	11.3	0+	0.6
SIERRA	100		0	32	0	0	0+
SISKIYOU	100		17	313	54.3	0+	0.1
SOLANO	89		228	2,533	90.0	0.4	0.8
SONOMA	81		603	697	865.1	1.0	0.2
STANISLAUS	95		55	4,987	11.0	0.1	1.5
SUTTER	98		55	1,083	50.8	0.1	0.3
TEHAMA	99		0	430	0	0	0.1
TRINITY	100		0	58	0	0	0+
TULARE	90		56	3,339	16.8	0.1	1.0
TUOLUMNE	100		16	288	55.6	0+	0.1
VENTURA	83		471	5,140	91.6	0.8	1.6
YOLO	59		101	854	118.3	0.2	0.3
YUBA	99		0	115	0	0	0+
(Other)			32	-	-	0.1	-

SUPPLEMENTARY APPENDIX TO BRIEF:
MATERIALS ON LEGAL, MEDICAL, AND
SOCIAL IMPACT OF ABORTION LAW
RESTRICTIONS IN THE UNITED STATES

This Supplementary Appendix consists of offset reproductions of particularly relevant legal, medical, and social science publications, all of which are in the public domain.

Legal materials and commentary include a table showing in simplified form the types of statutes regulating the medical procedure of induced abortion in the United States. Also set out are the most recent versions of proposals by the Commissioners on Uniform State Laws, and the American Law Institute, as well as statutes and regulations from the State of Washington and New York.

Similarly included, for the Court's convenience, are offset copies of all major court decisions, both state and federal, which passed upon significant substantive and procedural points in cases which questioned the validity of restrictions on medical abortion.

Finally, the principal medical and social science publications concerning relevant aspects of medical abortion incidence, safety, and need, have also been offset and included in this Appendix. None of the materials are highly technical, and several have been noticed judicially in support of state and federal decisions. E.g., California v. Belous, 71 Cal. 2d 954, 965, 458 P.2d 194, 200, 80 Cal. Rptr. 354, 360 (1969), cert. denied, 397

915 (1970); McCann v. Babbitz, 310 F. Supp. 293, 301 (E.D. Wis.) (per curiam), appeal dismissed, 400 U.S. 1 (1970)(per curiam). These materials are included to ensure that the Court will not be without what Judge Learned Hand denominated as "the aid of unpartisan and authoritative scientific assistance in the administration of justice" in this case. Parke-Davis & Co. v. H.K. Mulford Co., 189 Fed. 95, 115 (C.C.S.D.N.Y. 1911).

The subject matter of this case - restrictions on the medical procedure of abortion - is particularly susceptible to predisposition. What in scientific circles is accepted fact may in other circles be heresy. The folklore on abortion, contraception, and human fertility in general is not likely to rest on firm scientific foundations. Only a few short years ago, an examination of texts used in medical schools revealed that "[t]wo thirds of the texts (25 texts) contained either no mention of contraception or only isolated reference to it, with no complete discussion." Tietze, et al., Teaching of Fertility Regulation in Medical Schools, 196 J. American Medical Ass'n 20, 23 (1966). If the medical profession only recently began to examine and understand contraception, with abortion lagging years behind, it is not to be expected that lawyers, judges, and the public at large would be fully knowledgeable in either or both fields.

As indicated above, the lower state and federal courts have taken judicial notice of non-record scientific materials needed for a full understanding of the subject matter of abortion. This

practice has firm foundations in decisions dating back throughout this century. Facts pertaining to the discriminatory impact of laws fair on their face have been noticed in Reynolds v. Sims, 377 U.S. 533 (1964)(voter distribution); social and economic conditions in West Coast Hotel Co. v. Parrish, 300 U.S. 379, 399 (1936); studies by public and private agencies in Muller v. Oregon, 208 U.S. 412, 419-21 (1908); published statistics in Parker v. Brown, 317 U.S. 341, 363 (1942); and even letters from knowledgeable citizens, as in American Federation of Labor v. American Sash & Door Co., 335 U.S. 538, 551 (1949)(Frankfurter, J. concurring).

Much of the scientific data relevant to this case was not in assembled or published form until recent months. Other items were not unearthed from medical libraries until recently. All of what is included has been carefully sifted in order to present the most directly relevant materials. It is the hope of the parties that these materials will be of use to the Court in reaching an informed and just decision.

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tem o.	Author, Title, Description	Page in App.	[No. pp.
	I. REGULATIONS, LAWS, AND GUIDELINES CONCERNING ACCESS TO MEDICAL ABORTION IN THE UNITED STATES.		
1.	National Center for Family Planning Services, Health Services and Mental Health Administration, Department of Health, Education and Welfare, *Current Status of Abortion Laws--August 1, 1970* (1970) (updated). (Chart indicating current provisions of abortion laws in effect in all fifty states.)	1	[1]
2.	Commissioners on Uniform State Laws, Uniform Abortion Act (2d Tentative Draft, 3d Working Draft, Aug. 4, 1970). (Draft sanctioning medical procedure of abortion as lawful in first 24 weeks and permitting non-hospital clinics.)	3	[2]
3.	American Law Institute, Model Penal Code §230.3 (Proposed Official Draft, 1962).	5	[3]
4.	New York State Abortion Law, N.Y. Penal Law §125.05(3), at 79 (McKinney Supp. 1970-1971). (Statute permitting elective abortion in first 24 weeks of gestation, as a sanctioned medical procedure.)	9	[1]
5.	New York City Health Code, tit. III, art. 42, 98 City Record 6313-15 (Oct. 23, 1970). (Guidelines for non-hospital abortion clinics.)	11	[4]
6.	Washington State Abortion Law, Rev. Code Wash. Ann., tit. 9, §§9.02.060 to 9.02.090 (Supp., 1970) (Laws 1970, c.3). (Referendum statute permitting elective abortion up to 18 weeks of pregnancy.)	15	[2]
7.	Abortion Regulations Adopted by the Washington State Board of Health, WAC 248-140 (December 10, 1970). (Guidelines for licensure of non-hospital abortion clinics.)	17	[6]
8.	American College of Obstetricians and Gynecologists, Policy on Abortion (Aug. 1970). (Policy of the A.C.O.G. giving medical sanction to the performance of abortion upon request of the patient.)	23	[1]

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American Public Health Association, Recommended Standards for Abortion Services (Nov. 1970). (Statement of the A.P.H.A. recognizing abortion services as an integral part of health care and sanctioning the performance of abortion outside of hospitals in specialized clinics.) 25 [8]

American Medical Association, Policy Regarding Abortion (June, 1970). 33 [1]

Constitution of the World Health Organization. (Statement stressing the right of access to health care.) 35 [1]

National Association for the Repeal of Abortion Laws, National Organizations Recommending Repeal of Abortion Laws. 37 [1]

II. FEDERAL AND STATE COURT DECISIONS

A. CASES BEFORE THE SUPREME COURT OF THE UNITED STATES

United States v. Vuitch, 402 U.S. 62 (April 21, 1971). 39 [38

Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex., June 17, 1970) (per curiam) (GOLDBERG, Cir. J. and HUGHES & TAYLOR, D.JJ.), *juris. postponed*, 402 U.S. ___(No. 808, 1970 Term; renumbered No. 70-18, 1971 Term). (Decision of a three-judge Federal court granting standing to a pregnant woman and a physician, and holding the Texas anti-abortion statute unconstitutional as an infringement of the right to privacy, unsupported by a compelling state interest; and void for vagueness. The court declined to grant injunctive relief.) 77 [9]

Doe v. Bolton, 319 F. Supp. 1048 (N.D. Ga., July 31, 1970; *Supplemental Opinion*, Oct. 14, 1970) (per curiam) (MORGAN, Cir. J. and SMITH & HENDERSON, D.JJ.) *juris. postponed*, 402 U.S. ___(No. 971, 1970 Term; renumbered No. 70-40, 1971 Term). (Decision of a three-judge Federal court granting standing to plaintiffs and holding portions of the Georgia Therapeutic Abortion Act unconstitutional. The court held that the state cannot limit the reasons for which an abortion is sought, although it can regulate abortion procedures beyond the basic requirement that they be performed by licensed physicians. In a Supplemental Opinion the court held that 87 [1

hospital committees cannot adopt strict abortion standards similar to those struck down in the statute.)

B. DECISIONS BY HIGHEST STATE COURTS

California v. Belous, 71 Cal. 2d 954, 458 P.2d 194, 80 Cal. Rptr. 354 (Sept. 5, 1969) (per PETERS, 4-3 decision), *cert. denied*, 397 U.S. 915 (1970). (Landmark decision of California Supreme Court striking down pre-1967 anti-abortion statute, permitting abortion only when "necessary to preserve her life," as void for vagueness. The Court also found "a fundamental right of the woman to choose whether to bear children" following from "right to privacy" decisions. The Court argued that the compelling state interest, based on the medical dangers of abortion in an earlier time, which would be required before such a strict abortion statute could be held constitutional, no longer exists today.) 99 [19

State v. Jamieson, 480 P.2d 87 (Kan., Jan. 23, 1971). (Decision of Kansas Supreme Court overturning conviction of a physician under anti-abortion statute on grounds that the information was invalid for failing to negate the exception to the definition of criminal abortion, "unless necessary to preserve the life of said woman.") 119 [5]

C. DECISIONS BY FEDERAL DISTRICT COURTS

1) DECISIONS INVALIDATING ABORTION LAWS IN WHOLE OR IN PART

Doe v. Scott, 321 F. Supp. 1385 (N.D. Ill., Jan. 29, 1971) (SWYGERT Cir. J. and ROBSON & CAMPBELL, D.JJ.) (2-1 decision, Campbell dissenting), *appeal docketed sub nom. Hanrahan v. Doe*, 39 U.S.L.W. 3438 (U.S. Mar. 29, 1971) (No. 1522, 1970 Term; renumbered No. 70-105, 1971 Term). (Decision of a three-judge Federal court granting standing to women seeking abortions and to certain physicians, declaring Illinois anti-abortion statute unconstitutional, and granting permanent injunction. The court held that the statute (permitting abortion only to preserve the woman's life) was unconstitutionally vague and a violation of a woman's right to life and privacy. No legitimate or compelling state interest in fetal life permitted the state to prohibit first trimester abortions performed by licensed physicians in licensed medical facilities.) 125 [13]

Doe v. Rampton, No. C-234-70 (D. Utah, Sept. 14, 1970) (per curiam) (RITTER, D.J.). (Order of a single Federal district judge temporarily restraining enforcement of Utah anti-abortion statute in light of its probable unconstitutionality.) 139 [2]

Doe v. Bolton, supra.

Roe v. Wade, supra.

Babbitz v. McCann (I), 310 F. Supp. 293 (E.D. Wis., March 5,1970) (per curiam) (KERNER, Cir. J. and REYNOLDS & GORDON, D.JJ.), *appeal dismissed*, 400 U.S. 1 (1970) (per curiam). (Decision of a three-judge court declaring Wisconsin's anti-abortion statute unconstitutional as an invasion of a woman's right to privacy guaranteed by the Ninth Amendment. The court held that any state interest in the fetus was out-weighed by the rights of the pregnant woman.) 141 [1

Babbitz v. McCann (II), 320 F. Supp. 219 (E.D. Wis., Nov. 18, 1970) (per curiam) (KERNER, Cir. J. and REYNOLDS & GORDON, D.JJ.), *vacated*, 402 U.S. 903 (1971). (Decision of three-judge court granting previously denied injunctive relief, vacated by the Supreme Court for reconsideration in light of *Younger v. Harris*, 401 U.S. 37 (1971), and companion cases.) 151 [5

Harling v. Department of Health and Social Services, 323 F. Supp. 899 (E.D. Wis., March 11, 1971) (GORDON, D.J.). (Decision of district court judge setting aside conviction of a non-physician for violation of abortion law, in light of *Babbitz v. McCann* (I), *supra*.) 157 [3

Kennan v. Nichol, No. 71-C-118 (W.D. Wis., April 27, 1971) (DOYLE, D.J.). (Decision of district judge enjoining prosecution of doctor for violations of Wisconsin abortion statute in light of *Babbitz v. McCann* (I), *supra*, on the ground that the federal proceeding pre-dated the state criminal proceeding and was therefore not precluded by the "anti-injunction" statute.) 161 [5

Kennan v. Warren, No. 71-C-132 (W.D. Wis., May 5, 1971; Supplemental Opinion, May 6, 1971) (DOYLE, D.J.). (Decision of district judge enjoining additional civil proceedings taken against same physician as in *Kennan v. Nichol, supra*.) 167 [

2) FEDERAL DECISIONS UPHOLDING ABORTION LAWS

Corkey v. Edwards, 322 F. Supp. 1248 (W.D. N.C., Feb 1, 1971) (CRAVEN, Cir. J. and JONES & McMILLAN, D.JJ.), *appeal docketed*, 40 U.S.L.W. 3048 (U.S. July 17, 1971) (No. 71-92, 1971 Term). (Decision of three-judge court upholding North Carolina's Therapeutic Abortion Act. The court held that a state interest in the fetus was sufficient to support the statute against constitutional challenge. The court struck down a four month residency requirement for abortion as a violation of the right to travel.) 181 [8]

Steinberg v. Brown, 321 F. Supp. 741 (N.D. Ohio, Dec. 18, 1970) (WEICK, Cir. J. and GREEN & YOUNG, D.JJ.) (2-1 decision, Green dissenting) (not appealed). (Decision of a three-judge court upholding Ohio anti-abortion statute by finding the statute not vague and a legitimate exercise of state power to protect the fetus. In a dissenting opinion Judge Green found the statute in violation of the Fourteenth Amendment and the right to privacy. In addition, he challenged the majority's interpretation of the statute's legislative history.) 189 [21]

Rosen v. Louisana, 318 F. Supp. 1217 (E.D. La., Aug. 7, 1970) (AINSWORTH, Cir. J. and CASSIBRY & BOYLE, D.JJ.) (2-1 decision, Cassibry dissenting), *appeal docketed*, 39 U.S.L.W. 3247 (U.S. Nov. 27, 1970) (No. 1010, 1970 Term; renumbered No. 70-42, 1971 Term). (Decision of three-judge court upholding Lousiana statute authorizing revocation of medical doctor's license for performing abortions. The court found the statute not vague and a valid exercise of power to protect the fetus. In his dissent Judge Cassibry held the statute constitutionally infirm on numerous grounds including violation of the right to privacy, and denial of equal protection to the poor.) 211 [29]

D. STATE LOWER COURT DECISIONS

1) STATE LOWER COURT DECISIONS INVALIDATING ABORTION LAWS IN WHOLE OR IN PART

Rogers v. Danforth, No. 315512 (Mo. Cir. Ct. St. Louis, June 7, 1971) (LASKY, J.). (Decision of trial court finding Missouri anti-abortion statute void for vagueness and in violation of the First, Fourth, Fifth, Ninth, and Fourteenth Amendments. 241 [3]

People v. Gwynne, No. 173309 (Central Orange Cnty. Mun. Ct., Calif., June 16, 1970) (THOMPSON, J.). (Decision of a trial judge that California statute goes beyond legitimate health purposes and is an unconstitutional infringement of the rights to life and liberty protected by the Fourteenth Amendment.) 245 [5

People v. Robb, Nos. 149005 and 159061 (Central Orange Cnty. Mun. Ct., Calif., Jan. 7, 1970) (MAST, J.). (Decision of trial judge finding California statute in violation of U.S. Constitution on various grounds including: improper delegation of legislative authority (accreditation and hospital committee provisions), vagueness, denial of equal protection, and interference with the right to privacy.) 251 [8

People v. Barksdale, No. 33237C (San Leandro-Hayward Mun. Ct., Alameda Cnty., Calif., March 24, 1970) (FOLEY, J.). (Decision of trial judge indicating his concurrence in *People v. Robb, supra*.) 259 [9

People v. Barksdale, ___Cal.App. 3d__, __ Cal. Rptr. ___, 1 Crim. 9526 (Calif. Dist. Ct. App. July 22, 1971). (Decision of intermediate appellate court invalidating major portions of A.L.I.-type therapeutic abortion act, in particular a provision limiting abortions to hospitals accredited by the private Joint Commission on Accreditation of Hospitals.) 268-1 [

Shively v. Board of Medical Examiners, No. 590333 (Calif. Super. Ct. San Francisco Cnty., Sept. 24, 1968) (HYMAN, J.) *on remand from* 65 Cal. 2d 475, 421 P.2d 65, 55 Cal. Rptr. 217 (1968). (Decision of a trial judge that defendant physician was not guilty of performing criminal abortion under pre-1967 statute in performing therapeutic abortion in conformity with accepted medical practice on women who had contracted rebella. The court held that a woman's right to therapeutic abortion in these circumstances was protected by the Eighth and Fourteenth Amendments. The court also held that the state must prove that the exception ("necessary to preserve her life") had not been met.) 269

People v. Anast, No. 69-3429 (Ill. Cir. Ct. Cook Cnty., July 29, 1970) (DOLEZAL, J.) (Decision of trial judge holding Illinois anti-abortion statute unconstitutionally vague and in violation of a woman's right to privacy. The court also held that the indictment failed to state the crime of "soli- 275

tation" in alleging only that the defendant encouraged women to procure abortions.)

4. *Commonwealth v. Page*, No. 1968-353 (Pa. Ct. Comm. Pl., Centre Cnty., July 23, 1970) (CAMPBELL, J.). (Decision of a trial court holding Pennsylvania statute unconstitutional as violative of due process and equal protection standards of the Fourteenth Amendment and as an infringement of a woman's right to privacy.) 279

5. *State v. Munson*, No. 24949 (S. Dak. 7th Cir. Ct., Pennington Cnty., April 6, 1970) (COOPER, J.). (Decision of trial court holding South Dakota statute unconstitutionally vague and an invasion into private conduct unsupported by vital interests of the state.) 283

6. *State v. Ketchum*, (Mich. Dist. Ct., March 30, 1970) (REID, J.). (Decision of a trial judge holding Michigan anti-abortion law void for vagueness and in violation of the right to privacy.) 287

2) STATE LOWER COURT DECISIONS UPHOLDING ABORTION LAWS

7. *State v. Hodgson*, No. 23789 (Minn. Dist. Ct., Ramsey Cnty., June 29, 1970) (HACKEY, J.). (Decision of trial court upholding Minnesota anti-abortion statute in prosecution of a physician for performing a therapeutic abortion in a hospital. The court held that the state's interest in the fetus was sufficient to support the law.) 289

Commonwealth v. Brunelle, No. 83879 (Mass. Super. Ct., Middlesex Cnty., Dec. 1970) (MOYNIHAN, J.). (Decision of trial judge upholding the constitutionality of the Massachusetts anti-abortion statute. The court found no establishment of religion by the statute and no interference with the woman's right to privacy in light of the state's interest in the fetus.) 307

III. LEGAL COMMENTARY

Tom C. Clark, *Religion, Morality and Abortion: A Constitutional Appraisal*, 2 Loyola U. (L.A.) Law Rev. 1 (1969). (Article by the retired Supreme Court Justice who argues that no compelling state interest exists that would 315

constitutionally permit the state to place restrictions on obtaining abortion other than those designed to insure the safety of the procedure.

William Curran & S.M. Hyg, *The Right to Health in National and International Law,* 284 New England J. of Med. 1258 (1971). (Brief discussion of an emerging concept, the "right to health.") 327

Ruth Roemer, *Abortion Law Reform and Repeal: Legislative and Judicial Developments,* 61 Am. J. Pub. Health 500 (1970). (Review of recent judicial decisions and legislative action concerning abortion.) 329

IV. MEDICAL AND SOCIAL SCIENCE STUDIES ON ABORTION PRACTICES

L. Bumpass & C. Westoff, *The "Perfect Contraceptive" Population,* 169 Science 1177 (Sept. 1970). (Demographic analysis finding high degree of unwanted fertility in the U.S. and measuring the effects of unwanted births on population trends.) 339

R. Lerner, *Geographic Distribution of Need for Family Planning and Subsidized Services in the United States,* 60 Am. J. Pub. Health 1945 (Oct. 1970). (Review of a massive government survey of the availability of family planning services to low-income women which found that 85% of such women had no access to family planning programs.) 345

C. Muller, *Socioeconomic Outcomes of Restricted Access to Abortion,* 61 Am. J. Pub. Health 1110 (June, 1971). (Review of the impact of restricted abortion and the resultant unwanted births on a broad range of social problems.) 357

H. Forssman & I. Thuwe, *One Hundred and Twenty Children Born After the Application for Therapeutic Abortion Refused,* in Abortion and the Unwanted Child, Carl Reiterman, ed. (1970). (Long-term study of the psychological development of unwanted children born after an application for abortion was denied.) 367

R. Hall, *Abortion in American Hospitals,* 57 Am. J. Pub. Health 1933 (Nov. 1967). (Study of the practice of 391

abortion in American hospitals finding gross inequality and inconsistency in the administration of abortion regulations.)

7. R. Hall, *Therapeutic Abortion, Sterilization, and Contraception*, 91 Am. J. Obstetrics & Gynecology 518 (Feb. 1965). (Results of a survey of hospitals finding, in particular, a far higher incidence of therapeutic abortion for private patients than for ward patients.) 396

8. A. Margolis, *et al.*, *Therapeutic Abortion Follow-Up Study*, 110 Am. J. Obstetrics & Gynecology 243 (May, 1970). (Results of a study of women who had undergone an abortion, finding no evidence of psychological damage.) 411

9. G. Walter, *Psychologic and Emotional Consequences of Elective Abortion*, 36 Obstetrics & Gynecology 482 (Sept. 1970). (Review of studies of psychological reaction to abortion, finding no evidence of significant abortion-related distress.) 419

B. HEALTH AND SAFETY ASPECTS OF ABORTION

Eastman & Hellman, Williams Obstetrics .1085 (13th ed. 1966). (Medical discussion of therapeutic abortion from the leading obstetrical textbook.) 429

C. Tietze, *Morality With Contraception and Induced Abortion*, 45 Studies in Family Planning 6 (Sept. 1969). (Comparison of safety rates among induced abortion, childbirth, and contraception- medical abortion found 7 times safer than childbirth.) 437

C. Tietze, *Abortion Laws and Abortion Practices in Europe*, V Advances in Planned Parenthood 194 (Excerpta Medica International Congress Series No. 207, 1969). (Detailed analysis of abortion practices in Europe, as to safety, incidence, and patient characteristics.) 439

A. Margolis & E. Overstreet, *Legal Abortion Without Hospitalization*, 36 Obstetrics & Gynecology 479 (Sept. 1970). (Study showing that overnight hospital stay after abortion not likely to reduce the minimal future complications.) 459

H. Harvey & B. Pyle, *On the Healthiness of Four Thousand Abortions in a Free Standing Clinic* (unpublished material). (Study of excellent medical safety rate at non-hospital clinic in New York City.) 463

S. Goldsmith & A. Margolis, *Aspiration Abortion Without Cervical Dilation*, 110 Am. J. Obstetrics & Gynecology 580 (June, 1971). (Study of relatively uncomplicated abortion technique adaptable for non-hospital use with exceptional safety features.) 469

Penfield, *Abortion Under Paracervical Block*, 71 N.Y. State J. of Med. 1185 (June, 1971). (Analysis of 600 first trimester abortions under local anesthesia, concluding that procedure suitable for well-equipped office.) 473

I.

REGULATIONS, LAWS, AND GUIDELINES CONCERNING ACCESS TO MEDICAL ABORTION IN THE UNITED STATES

CURRENT STATUS OF ABORTION LAWS - August 1, 1970

Statutes provide that abortions are permitted for the reasons indicated and under the conditions specified.

State	Year	Physician	Hospital	Life	Health	Physical Health	Mental Health	Fetal Deformity	Forcible Rape	Statutory Rape (Age)	Incest	Time Limit (Weeks)	M.D. Approval	Residency
ALABAMA	1951													
ALASKA	1970	√	√[1]	√	√							•		√ 30 days
ARIZONA	1965			√										
ARKANSAS	1969	√	√	√	√									
CALIFORNIA	1967	√	√	√		√	√	√	√		√		3C	√ 4 mos
COLORADO	1967	√	√	√		√	√	√	√	√(15)	√	√(20)	2 3B[3]	
CONNECTICUT	1860			√					√	√(16)	√	√(16)[3]	3B	
DELAWARE	1969	√	√	√		√	√	√	√		√	√(20)[4]	1C RA	√ 4 mos[5]
DIST. OF COL.	1901			√	√									
FLORIDA	1868			√										
GEORGIA	1968	√	√	√	√			√	√	√(14)		•	2C 3B	√
HAWAII	1970	√	√											√ 20 days[6]
IDAHO	1863			√										
ILLINOIS	1876			√										
INDIANA	1838			√										
IOWA	1843			√										
KANSAS	1969	√	√[7]	√		√	√	√	√	√(16)	√		3C	
KENTUCKY	1910			√										
LOUISIANA	1914			√										
MAINE	1840			√									1C	
MARYLAND	1968	√	√	√		√	√	√	√			√(20)[8]	RA	
MASSACHUSETTS	1845			√[9]	√[9]									
MICHIGAN	1846			√										
MINNESOTA	1861			√										
MISSISSIPPI	1966	√		√					√[10]	√[10]				
MISSOURI	1836			√									2C	

State	Year	Physician	Hospital	Life	Health	Physical Health	Mental Health	Fetal Deformity	Forcible Rape	Statutory Rape (Age)	Incest	Time Limit (Weeks)	M.D. Approval	Residency
MONTANA	1864			√										
NEBRASKA	1873			√										
NEVADA	1861			√										
NEW HAMPSHIRE	1848			√										
NEW JERSEY	1849			√[11]										
NEW MEXICO	1969	√	√	√		√	√	√	√	√(18)	√		2B	
NEW YORK	1970	√										√(24)[13]		
N. CAROLINA	1967	√	√	√	√			√	√		√		3C	√ 30 days
N. DAKOTA	1943			√										
OHIO	1841			√										
OKLAHOMA	1910			√										
OREGON	1969	√	√	√		√[12]	√[12]	√	√	√(18)	√	√ 150 days[14]	1C	√
PENNSYLVANIA[15]	1860													
PUERTO RICO	1913			√										
RHODE ISLAND	1868			√										
S. CAROLINA	1970	√	√	√		√	√	√	√		√		3C	√ 90 days
S. DAKOTA	1939			√										
TENNESSEE	1883			√										
TEXAS	1859			√										
UTAH	1876			√										
VERMONT	1867			√										
VIRGINIA	1970	√	√	√		√	√	√	√		√		Board	√ 120 days[16]
WASHINGTON	1970	√	√									√ 16		√ 90 days
WEST VIRGINIA	1849			√										
WISCONSIN	1849			√									2C	
WYOMING	1959			√										

C – Consultant; B – Therapeutic Abortion Board; RA – Hospital Review Authority

*Non-Viable Fetus

[1] Abortion must be "performed in a hospital or other facility approved for the purpose by the Department of Health and Welfare or a hospital operated by the federal government or an agency of the federal government . . ." Abortion may not be performed unless "consent has been received from the parent or guardian of an unmarried woman less than 18 years of age . . ."

[2] Two-member abortion board required through the 12th week of pregnancy, three-member board thereafter

[3] The 16-week time limit applies to rape and incest only.

[4] After 20 weeks a pregnancy may be terminated to preserve the women's life or where the fetus is dead

[5] Residency requirement does not apply if the woman or her husband works in Delaware or if she has previously been a patient of a Delaware physician or if her life is in danger.

[6] "The affidavit [re residency] of such a woman shall be prima facie evidence of compliance with the requirement."

[7] Abortion must be done in a hospital "or other place as may be designated by law . . ."

[8] After 26 weeks a pregnancy may be terminated to preserve maternal life or when the fetus is dead.

[9] The statute prohibits "unlawful" abortion, or abortion which is "malicious" or performed "without lawful justification." Case law, however, sanctions abortion to preserve maternal life and protect maternal health. COMMONWEALTH V. WHEELER (1968).

[10] Statute does not specify whether forcible or statutory rape (or either) is meant.

[11] The statute forbids abortions done "maliciously or without lawful justification." Case laws provide that abortions are permitted at least to preserve the life of the woman. GLEITMAN V. COSGROVE (1967).

[12] After 24 weeks pregnancy may be terminated only to preserve women's life.

[13] "In determining whether or not there is substantial risk [to her physical or mental health] account may be taken of the mother's total environment, actual or reasonably foreseeable."

[14] The 150-day time limit does not apply in cases of danger to life.

[15] "Unlawful" abortion is proscribed but not defined.

[16] Residency may be proved by affidavit.

Primary source: *Checklist of Abortion Laws in the United States*. Association for the Study of Abortion, Inc., 1970.

Lader, Lawrence. "A National Guide to Legal Abortion." *Ladies' Home Journal*. July 1970

Prepared by NATIONAL CENTER FOR FAMILY PLANNING SERVICES, HSMHA, HEW

Item No. 1

Item No. 2

August 4, 1970

Second Tentative Draft
(Third Working Draft)

UNIFORM ABORTION ACT

SECTION 1. *[Abortion defined; Prohibited; Exceptions.]*

(a) "Abortion" means the intentional termination of human pregnancy other than by live birth.

(b) No abortion shall be performed in this state unless it is performed:

(1) by a physician licensed to practice medicine [or osteopathy] in this state or by a physician practicing medicine [or osteopathy] in the employ of the government of the United States or of this state, [and the abortion is performed in the physician's office or in a medical clinic, or in a hospital approved by the [Department of Health] or operated by the United States, this state or any department, agency, or political subdivision of either;] or

(2) by a female upon herself upon the advice of a licensed physician [; and in either case]

(3) within 24 weeks after the commencement of the pregnancy; or if after 24 weeks, the physician believes there is a substantial risk that continuance of the pregnancy would endanger the life of the mother or would gravely impair the physical or mental health of the mother, or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape or incest, or illicit intercourse with a girl under 16 years of age.]

(c) Any person who violates this section is guilty of a [felony] and, upon conviction thereof, may be sentenced to pay a fine not exceeding [$1,000] or to imprisonment [in the state penitentiary] not exceeding [5 years], or both.

SECTION 2. *[Uniformity of Interpretation].* This Act shall be construed to effectuate its general purpose to make uniform the law of those states which enact it.

SECTION 3. *[Short Title.]* This Act may be cited as the Uniform Abortion Act.

SECTION 4. *[Severability.]* If any provision of this Act or the application thereof to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

SECTION 5. *[Repeal.]* The following acts and parts of acts are repealed:

(1)

(2)

(3)

SECTION 6. *[Time of Taking Effect.]* This Act shall take effect _____.

Model Penal Code (Proposed Official Draft, 1962)

Section 230.3. Abortion.

(1) Unjustified Abortion. A person who purposely and unjustifiably terminates the pregnancy of another otherwise than by a live birth commits a felony of the third degree or, where the pregnancy has continued beyond the twenty-sixth week, a felony of the second degree.

(2) Justifiable Abortion. A licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse. All illicit intercourse with a girl below the age of 16 shall be deemed felonious for

purposes of this subsection. Justifiable abortions shall be performed only in a licensed hospital except in case of emergency when hospital facilities are unavailable. [Additional exceptions from the requirement of hospitalization may be incorporated here to take account of situations in sparsely settled areas where hospitals are not generally accessible.]

(3) Physicians' Certificates; Presumption from Non-Compliance. No abortion shall be performed unless two physicians, one of whom may be the person performing the abortion, shall have certified in writing the circumstances which they believe to justify the abortion. Such certificate shall be submitted before the abortion to the hospital where it is to be performed and, in the case of abortion following felonious intercourse, to the prosecuting attorney or the police. Failure to comply with any of the requirements of this Subsection gives rise to a presumption that the abortion was unjustified.

(4) Self-Abortion. A woman whose pregnancy has continued beyond the twenty-sixth week commits a felony of the third degree if she purposely terminates her own pregnancy otherwise than by a live birth, or if she uses instruments, drugs or violence upon herself for that purpose. Except as justified under Subsection (2), a person who induces or knowingly aids a woman to use instruments, drugs or violence upon herself for the purpose of terminating her pregnancy otherwise than by a live birth commits a felony of the third degree whether or not the pregnancy has continued beyond the twenty-sixth week.

(5) Pretended Abortion. A person commits a felony of the third degree if, representing that it is his purpose to perform an abortion, he does an act adapted to cause abortion in a pregnant woman although the woman is in fact not

pregnant, or the actor does not believe she is. A person charged with unjustified abortion under Subsection (1) or an attempt to commit that offense may be convicted thereof upon proof of conduct prohibited by this Subsection.

(6) Distribution of Abortifacients. A person who sells, offers to sell, possesses with intent to sell, advertises, or displays for sale anything specially designed to terminate a pregnancy, or held out by the actor as useful for that purpose, commits a misdemeanor, unless:

(a) the sale, offer or display is to a physician or druggist or to an intermediary in a chain of distribution to physicians or druggists; or

(b) the sale is made upon prescription or order of a physician; or

(c) the possession is with intent to sell as authorized in paragraphs (a) and (b); or

(d) the advertising is addressed to persons named in paragraph (a) and confined to trade or professional channels not likely to reach the general public.

(7) Section Inapplicable to Prevention of Pregnancy. Nothing in this Section shall be deemed applicable to the prescription, administration or distribution of drugs or other substances for avoiding pregnancy, whether by preventing implantation of a fertilized ovum or by any other method that operates before, at or immediately after fertilization.

N. Y. Penal Law §125.05(3), at 79 (McKinney Supp.1970-1971)

* * * * *

3. "Justifiable abortional act." An abortional act is justifiable when committed upon a female with her consent by a duly licensed physician acting (a) under a reasonable belief that such is necessary to preserve her life, or, (b) within twenty-four weeks from the commencement of her pregnancy. A pregnant female's commission of an abortional act upon herself is justifiable when she acts upon the advice of a duly licensed physician (1) that such act is necessary to preserve her life, or, (2) within twenty-four weeks from the commencement of her pregnancy. The submission by a female to an abortional act is justifiable when she believes that it is being committed by a duly licensed physician, acting under a reasonable belief that such act is necessary to preserve her life, or, within twenty-four weeks from the commencement of her pregnancy.

As amended L.1970, c. 127, eff. July 1, 1970.

Item 5

HEALTH SERVICES ADMINISTRATION DEPARTMENT OF HEALTH

Resolution Adopted

AT A MEETING OF THE BOARD OF HEALTH OF THE DEPARTMENT OF Health held September 17, 1970, the following resolution was adopted:

Resolved, That the schedule of article headings of Title III of the New York City Health Code, as enacted by resolution adopted on the twenty-third day of March, nineteen hundred fifty-nine and filed with the City Clerk on the twenty-fourth day of March, nineteen hundred fifty-nine, be and the same hereby is amended by adding thereto a new article heading, to follow the article heading "ARTICLE 41 MATERNITY AND NEWBORN SERVICES," to read as follows:

ARTICLE 42 ABORTION SERVICES

Resolved further, that such Title be and the same hereby is amended, by adding a new Article 42 thereto, to follow Article 41 thereof, to be printed together with explanatory notes, to read as follows:

Section
42.01 Definitions
42.03 Requirements and standards
42.05 Filing of staff and service regulations
42.07 Records and reports; inspection
42.09 Compliance with Title V, Vital Statistics
42.11 Facilities, equipment and supplies generally
42.13 Transportation facilities for affiliated service
42.15 Elevators
42.17 Admission and examination facilities
42.19 Laboratory facilities
42.21 Operating facilities
42.23 Recovery room or rooms
42.25 Staff; physician in charge of abortion service; duties
42.27 Staff; nursing supervision of abortion patients
42.29 Staff; social service
42.31 Admission and examination procedures
42.33 Operative and post-operative requirements
42.35 Modification by Board

INTRODUCTORY NOTES

Article 42 was enacted by resolution of the Board of Health adopted on September 17, 1970 to provide public health standards of care in the performance of abortions, with proper regard for the health, safety and well-being of the patient. This article requires that abortions be performed only by physicians operating in a place or facility where there is qualified supervision in obstetrics or surgery, and where equipment, staff and facilities are provided to handle hemorrhage, shock, cardiac arrest and other emergencies, as well as to apply aseptic procedures. The article further protects the health of the patient by providing that abortions performed on women pregnant 12 weeks or less may be performed on an ambulatory basis; that pregnancies of longer duration or those involving medical, surgical, gynecological or psychiatric conditions, or complications occurring during or after the abortion, require inpatient facilities. The article also requires that family planning services should be made available to patients.

The article follows the enactment of a new abortion law (Chapter 127, Laws of 1970, effective July 1, 1970) by the State Legislature. The new law amended subdivision 3 of Section 125.05 of the State Penal Law to generally provide that an abortion performed within twenty-four weeks from the commencement of pregnancy by a physician with the consent of the pregnant female shall be a justifiable abortional act and, therefore, not subject to criminal prosecution under related provisions of the Penal Law.

§ 42.01 Definitions

When used in this article:

(a) Abortion service means a place or facility in which abortions are performed.

(b) Hospital means a hospital as defined in Section 700.2 (5) of the State Hospital Code.

(c) Affiliated abortion service means an abortion service which is located within a total transport time of ten minutes from a hospital with which such service has a written affiliation agreement for the treatment of its patients requiring care on an inpatient basis.

(d) Total transport time means the total elapsed time between the diagnosis, at an affiliated abortion service, of a complication requiring emergency care and the delivery of the patient and the transfer of responsibility for the patient's care to appropriate medical personnel at a hospital.

(e) Unaffiliated abortion service means an abortion service which is not located in a hospital and is not an affiliated abortion service.

(f) Qualified obstetrician means:

(1) A licensed physician who is a diplomate of the American Board of Obstetrics and Gynecology, or who submits evidence to the Department that his training and experience qualify him for admission to the examination by such Board; or,

(2) A licensed physician who is a fellow of the American College of Surgeons in the specialty of obstetrics and gynecology; or,

(3) A licensed physician who has the rank of associate attending obstetrician or higher at a voluntary or municipal hospital approved for residency training in obstetrics by the Council on Medical Education and Hospitals of the American Medical Association; or,

(4) A licensed physician who has the rank of assistant professor of obstetrics or gynecology or higher in a medical school approved by the Board of Regents of the University of the State of New York; or,

(5) A Doctor of Osteopathy who holds a license to practice medicine in the State of New York and who is certified by the American College of Osteopathic Obstetricians and Gynecologists, or who submits evidence to the Department that his training and experience qualify him for admission to the examination by such Board, or who submits evidence of completion of a residency in obstetrics and gynecology.

(g) Qualified surgeon means:

(1) A licensed physician who is a diplomate of the American Board of Surgery, or who submits evidence to the Department that his training and experience qualify him for admission to the examination by such Board; or

(2) A licensed physician who is a fellow of the American College of Surgeons; or

(3) A licensed physician who has the rank of associate attending surgeon or higher at an accredited voluntary or governmental hospital.

(h) Registered professional nurse means a person who is registered as a registered professional nurse by the State Department of Education pursuant to Article 139 of the Education Law.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.03 Requirements and standards

An abortion shall be performed in an abortion service operated in accordance with the provisions of this article and related provisions of this Code.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.05 Filing of staff and service regulations

An abortion service shall be maintained in accordance with a set of formal standards which define the professional qualifications of its obstetric, gynecological, surgical, nursing and administrative staff, and which govern the conduct of the service. These standards shall be prepared by the physician in charge of such service and a copy of such standards and any change or modification thereof shall be filed with the Department.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.07 Records and reports; inspection

(a) An abortion service shall keep records including admission and discharge notes, histories, results of tests and examinations, nurse's work sheets, social service records and other progress notes of patients, and it shall submit such records to the Department when the Department shall so require.

(b) An abortion service shall prepare reports which shall be submitted to the Department when it shall so require. Such reports shall include the number of:

(1) Patients requesting abortions;

(2) Patients on whom abortions were performed according to the period of gestation and method of termination of pregnancy;

(3) Patients for whom abortions were refused and the reasons therefor; and

(4) Patients referred to other abortion services.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.09 Compliance with Title V, Vital Statistics

Abortion services shall comply with applicable requirements of Title V of this Code.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.11 Facilities, equipment and supplies generally

Facilities, equipment and supplies in an abortion service shall be maintained in proper working order. Necessary solutions, drugs and medications shall be supplied and maintained pursuant to related provisions of Article 75. Knee or foot controlled sinks shall be provided in or immediately adjacent to the room where the abortion is performed. The abortion service facilities and equipment shall be maintained in a clean and sanitary condition.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.13 Transportation facilities for affiliated service

An affiliated abortion service shall have immediately available organized transportation facilities capable of insuring that a patient requiring emergency care at the hospital with which such service is affiliated will be transported to such hospital within the total transport time of ten minutes.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.15 Elevators

Any building of more than one story in height and of which an abortion service is a part shall be provided with an elevator for the use of non-ambulatory abortion patients. The elevator shall be of sufficient size to accommodate a standard stretcher. When a non-ambulatory abortion patient is moved from one floor to another, she shall be accompanied by attending medical or nursing personnel.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.17 Admission and examination facilities

An abortion service shall provide facilities for registration, medical evaluation, examination and referral, equipped with suitable furnishings and accommodations, including waiting and dressing rooms and other appurtenances for the physical comfort and convenience of patients and personnel. Sufficient, suitably equipped examining rooms shall be provided for the daily caseload. Nothing contained herein shall prohibit registration, interviewing, history-taking, medical examination and appropriate referral from being conducted in an existing prenatal, gynecology and/or family planning clinic.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.19 Laboratory facilities

(a) An unaffiliated abortion service or an abortion service located in a hospital shall have on its premises a blood bank maintained and operated pursuant to the requirements of Articles 17 and 19, a clinical laboratory maintained pursuant to Article 13 of this Code, and an X-ray laboratory which meets the requirements of Article 175. The clinical laboratory shall be qualified to perform urinalysis, hematocrit and other hematological tests including cross-matching and determinations of blood group and Rh type. The examination of surgically removed tissue, tests for pregnancy, and infrequently performed tests, or those not included within specialties or subspecialties stated on its permit, or those requiring specialized equipment and skill, may be forwarded to another laboratory approved by the Department.

(b) The affiliation agreement of an affiliated abortion service shall include provision for use in the hospital of those facilities required in subsection (a). However, the affiliated abortion service shall have on its premises such facilities as are necessary to perform clinical tests specified in the agreement.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.21 Operating facilities

(a) An unaffiliated abortion service or an abortion service located in a hospital shall have available on its premises a standard operating room capable of accommodating abdominal as well as vaginal surgical procedures. An affiliated abortion service shall include in its affiliation agreement provision for the use of a standard operating room in the treatment of its patients requiring care on an innatient basis.

(b) For abortions specified in Section 42.35(a), existing outpatient operating facilities may be utilized or new outpatient operating facilities created, if the policies established by the physician in charge of the abortion service and the patient load warrant. If it is found necessary to add to existing outpatient operating facilities, a standard sized treatment room may be converted to an operating facility.

(c) All rooms in which abortions are performed shall be adequately equipped, supplied and staffed and shall include the following in addition to the instruments and equipment needed for the performance of abortions.

(1) Anesthesia equipment and such other equipment as is necessary to treat patients for hemorrhage, shock, cardiac arrest, and other emergencies.

(2) In an unaffiliated abortion service or an abortion service located in a hospital an adequate supply of drugs, compatible whole blood, blood fractions, blood concentrates, plasma expanders and parenteral fluids immediately available at all times with appropriate refrigeration equipment therefor; in an affiliated abortion service an adequate supply of drugs, plasma expanders and parenteral fluids shall be available at all times with appropriate refrigeration equipment therefor;

(3) Dressing room and scrub-up facilities which are suitably located;

(4) A utility room with facilities for sterilization of bedpan and enema equipment.

(5) A utility room with facilities for sterilization of supplies, except in an abortion service which receives sterile supplies from a central supply service.

(d) The operating facilities and equipment shall be constructed and maintained so as to be free from sanitary hazards and safety hazards likely to cause a fire or explosion.

(e) Environmental controls to prevent infection, including the control of personnel and patient traffic, shall be maintained in the operating facilities.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.23 Recovery room or rooms

An adequately sized and separate recovery room or rooms in proximity to the operating facilities shall be provided. The recovery room shall contain adequate monitoring equipment, suction oxygen and other related equipment. Such room shall be staffed by qualified nursing personnel. An adequate number of recovery beds and/or rooms shall be provided to insure a minimum of three (3) hours for the recovery of each patient.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.25 Staff; physician in charge of abortion service; duties

(a) An abortion service shall be staffed so as to provide on the premises adequate medical, nursing, and ancillary personnel.

(b) The abortion service shall be supervised by a physician in charge who shall be a qualified obstetrician or, in a service which does not have a qualified obstetrician, by a qualified surgeon.

(c) The physician in charge of the abortion service shall be responsible for:

(1) Setting the policies and procedures pertaining to abortions and the implementation thereof; and

(2) Designating a licensed physician or physicians whom he deems qualified to supervise directly the care of all patients undergoing abortion, including their post-operative care and follow-up.

(3) Establishing standards for the observation of patients by nursing personnel during the post-operative period.

(d) A physician shall be present on the premises of the abortion service at all times during the operative and post-operative period.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.27 Staff; nursing supervision of abortion patients

(a) At least one registered professional nurse with post-graduate education or experience in obstetric or gynecologic nursing shall supervise and direct the nursing personned and care and shall be on duty in an abortion service at all times while in use.

(b) Student nurses, practical nurses, attendants and other ancillary personnel assigned to give nursing care in an abortion service shall be adequately trained in observational and emergency techniques for pre-operative and post-operative care of abortion patients and shall be supervised by registered professional nurses.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.29 Staff; social service

An abortion service shall have a social service unit available to serve its patients adequately.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.31 Admission and examination procedures

(a) Every woman seeking to terminate her pregnancy shall be registered as expeditiously as possible and, whenever possible, on the same day of registration she shall be seen by a physician and staff for history-taking, physical examination and necessary laboratory tests.

(b) If the patient cannot be accepted for registration and examination within a reasonable period of time, the abortion service shall refer her to an appropriate resource or to a central registry, and shall make every effort to secure treatment for her.

(c) Pregnancy testing should be available at the patient initial visit and may precede actual registration. The result and type of pregnancy test shall be available to the examining physician before the performance of the abortion. The diagnosis of pregnancy shall be the responsibility of the examining physician.

(d) A complete medical history shall be obtained and the physical examination shall be complete and not confined solely to a pelvic examination. The following laboratory tests shall be performed on every patient; hematocrit, complete urinalysis, blood grouping

and Rh typing. The blood specimen used for blood grouping and typing shall be retained by the blood bank in the event a cross-matching test for transfusion is required.

(e) Interviewing and counseling by social service staff shall be made available to patients before and after abortions are performed.

(f) Family planning counseling by such personnel as may be prescribed by the physician in charge of the service shall be made available to patients before and after abortions are performed.

(g) Where medical evaluation, examination and referral are made from a private physician's office, hospital, clinic or other abortion service pertinent records thereof shall be made available at the time the patient is registered and admitted to the abortion service. Proper policies and procedures for coordination or referral from various sources shall be established by the physician in charge of the abortion service and adhered to by all members of the staff.

(h) There shall be an interval of not less than two days between initial examination and termination of pregnancy to permit the reporting to and review of all laboratory tests by the examining physician and to permit and encourage thorough consideration and a firm decision by the patient regarding termination of pregnancy. No patient shall be coerced in any manner by the staff of the abortion service in arriving at her decision.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.33 Operative and post-operative requirements

(a) Abortions on patients with a gestation up to and including twelve weeks as determined by the physician may be performed on an ambulatory basis if the patient's medical condition permits.

(b) The following patients shall be treated on an inpatient basis for the abortion:

(1) Patients pregnant more than twelve weeks as determined by the physician;

(2) Patients having such medical, surgical, gynecological or psychiatric conditions or complications as specified in the rules of the chief of staff of the abortion service and filed with the Department pursuant to Section 42.05; and

(3) Patients having a sterilization procedure immediately following the abortion.

(c) Only physicians shall be permitted to perform abortions. Termination of pregnancies involving more than twenty weeks gestation shall not be performed by the physician without appropriate medical consultation.

(d) Where general or local anesthesia is administered to abortion patients it shall be administered pursuant to the requirements of Section 41.61.

(e) Pathologic examination of all tissue removed from the uterus shall be performed routinely.

(f) Patients shall receive the following post-operative care:

(1) Patients whose pregnancy was terminated on an ambulatory basis shall be observed in the abortion service for a reasonable number of hours, not less than three, to ensure that no immediate post-operative complications are present and thereafter such patients may be discharged if their course has been uneventful;

(2) Patients in whom any adverse condition exists or in whom a complication is known or suspected to have occurred during or after the performance of the abortion shall remain in the abortion service or the back-up hospital for a minimum of twenty-four hours.

(g) Written instructions shall be issued to all patients in accordance with the rules of the physician in charge of the abortion service and shall include the following:

(1) Symptoms of complications to be looked for;

(2) Activities to be avoided;

(3) Specific telephone number to be used by the patient should any complication occur or question arise;

(4) Date for follow-up or return visit after the performance of the abortion, which shall be scheduled within two to six weeks as indicated by the condition of the patient; and

(5) Information on the availability of family planning services when desired by the patient. When, in the opinion of the physician it is in the best interests of the patient, family planning services may be initiated, with the consent of the patient, prior to leaving the abortion service.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

§ 42.35 Modification by Board

When the strict applicability of any provision of this article presents practical difficulties or unusual hardships, the Board, in a specific instance, may modify the application of such provision consistent with the general purpose of this article and upon such condition as are necessary, in the opinion of the Board to protect the health of abortion patients.

NOTES: This section is new. It was enacted by resolution adopted on September 17, 1970.

Resolved further, that this resolution shall take effect immediately.

A true copy.

LORANCE HOCKERT, Secretary.

Filed with the City Clerk October 19, 1970. o23

Item No. 6

Rev. Code Wash. Ann., tit. 9, §§9.02.060 to 9.02.090 (Supp.1970) (Laws 1970, c.3):

§9.02.060. Neither the Termination by a physician licensed under Chapters 18.71 or 18.57 RCW of the pregnancy of a woman not quick with child nor the prescribing, supplying or administering of any medicine, drug or substance to or the use of any instrument or other means on, such woman by a physician so licensed, nor the taking of any medicine, drug or substance or the use or submittal to the use of any instrument or other means by such a woman when following the directions of a physician so licensed, with the intent to terminate such pregnancy, shall be deemed unlawful acts within the meaning of this act.

§9.02.070. A pregnancy of a woman not quick with child and not more than four lunar months after conception may be lawfully terminated under this act only: (a) with her prior consent and, if married and residing with her husband or unmarried and under the age of eighteen years, with the prior consent of her husband or legal guardian, respectively; (b) if the woman has resided in this state for at least ninety days prior to the date of termination; and (c) in a hospital accredited by the Joint Commission on Accreditation of Hospitals or at a medical facility approved for that purpose by the State Board of Health, which facility meets standards prescribed by regulations to be issued by the State Board of Health for the safe and adequate care and treatment of patients: PROVIDED, that if a physician determines that termination is immediately necessary to meet the medical emergency the pregnancy may be terminated elsewhere. Any physician who violates this section of this 1970 act or any regulation of the State Board of Health issued under authority of this section shall be guilty of a gross misdemeanor.

§9.02.080. No hospital, physician, nurse, hospital employee nor any other person shall be under any duty, by law or contract, nor shall such hospital or person in any circumstances be required, to participate in a termination of pregnancy if such hospital or person objects to such termination. No such person shall be discriminated against in employment or professional privileges because he so objects.

§9.02.090. If any provision of this act, or its application to any person or circumstance, is held invalid, the remainder of the act, or the application of the provision to other persons or circumstances, is not affected.

Item No. 7

ABORTION REGULATIONS ADOPTED

BY THE WASHINGTON STATE BOARD OF HEALTH

DECEMBER 10, 1970

WAC 248-140

Section 010 PURPOSE. It is the purpose of the Washington State Board of Health to establish guidelines to assure the safe and adequate care of patients undergoing termination of pregnancy, by means of rules and regulations setting standards for medical facilities at which pregnancies are terminated, in accordance with Chapter 3, Laws of 1970.

Section 020 DEFINITIONS. Unless the context clearly indicates otherwise, the following terms, whenever used in this chapter, shall be deemed to have the following meanings:

(1) "Board" means the Washington State Board of Health.

(2) "Department" means the Washington State Department of Social and Health Services, which shall serve as agent of the board.

(3) "Secretary" means the secretary of the Department of Social and Health Services or his designee or authorized representative.

(4) "Certificate of Approval" means a certificate issued in behalf of the board by the department to a facility approved for the performance of abortion procedures.

(5) "Clean" when used in reference to a room or area means space and/or equipment for storage and handling of supplies and/or equipment which are in a sanitary or sterile condition.

(6) "Facility" means any institution, place, building or agency or portion thereof in which an abortion procedure is performed.

(7) "Physician" means a doctor of medicine or a doctor of osteopathy duly licensed in the state of Washington.

(8) "Physical barrier" means a partition or similar space divider designed to prevent splash or spray between room areas.

(9) "Recovery unit" means a room or rooms for the segregation and close or continuous observation and care of patients immediately following an abortion procedure.

(10) "Soiled" when used in reference to a room or area, means space and equipment for collection and/or cleaning of used or contaminated supplies and equipment and/or collection and/or disposal of wastes.

Section 030 APPLICABILITY OF THESE RULES AND REGULATIONS. These standards, rules and regulations apply to any facility which is not an accredited hospital as set forth in Chapter 3, Laws of 1970, in which any drug, substance, instrument, or other means is administered or used to terminate the pregnancy of a woman, except that Section 12 shall apply to all accredited hospitals.

Section 040 CERTIFICATE OF APPROVAL REQUIRED. No person shall establish, maintain, or operate a facility in which any means are employed or actions taken for the purpose of terminating the pregnancy of a woman without a certificate of approval from the department: PROVIDED, that this provision shall not apply to accredited hospitals as set forth in Chapter 3, Laws of 1970.

Section 050 APPLICATION FOR CERTIFICATE OF APPROVAL. An application for a certificate of approval may be made to the department by nonaccredited, licensed hospitals and all other facilities upon forms provided by the department and shall contain such information as the department reasonably requires and which may include affirmative evidence of ability to comply with these standards, rules and regulations. An application for renewal of license shall be made to the department upon forms provided by it and submitted thirty days prior to the date of expiration of the certificate of approval.

Section 060 ISSUANCE, DURATION AND ASSIGNMENT OF CERTIFICATE OF APPROVAL. (1) Upon receipt of an application for a certificate of approval, the department shall issue a certificate of approval if the applicant and the facility meet the requirements, standards, rules and regulations established herein. Each certificate of approval shall be issued for the premises and persons named in the application and no certificate of approval shall be transferrable or assignable.

(2) If there be failure to comply with the standards, rules and regulations, the secretary may, when, in his judgment, the well-being and safety of patients would not be jeopardized, issue to an applicant for an initial or renewed certificate of approval, a provisional certificate of approval which will permit the operation of the facility for a specific, determined period of time. A provisional certificate of approval may be issued only when, after thorough investigation, it has been determined that time can be allowed for the facility

to correct existing deficiencies without placing in jeopardy the safety or health of women who receive services for the termination of pregnancy. In no case shall provisional approval exceed six months without review and sanction by the secretary.

Section 070 FORM OF APPLICATION FOR CERTIFICATE OF APPROVAL AND INSPECTION. The secretary shall prescribe the form upon which applications for approval shall be made, shall prior to the approval, within a reasonable time after application, evaluate the findings of inspections and issue a certificate of approval if the findings demonstrate conformity to the law and to these rules and regulations. A certificate of approval shall be valid immediately and for twelve months following the first day of the month following issuance, unless revoked for cause, and may be renewable. The secretary shall have access at any reasonable time, to the premises for which approval has been requested or has been issued, for purposes of ascertaining conformance to the law or to these rules and regulations.

Section 080 PROCEDURE UPON DENIAL OF APPLICATION FOR CERTIFICATE. Applicants denied approval shall have recourse to review of the decision of the secretary in conformance with the Administrative Procedure Act.

Section 090 HOSPITAL FACILITIES APPROVED FOR TERMINATING PREGNANCY. A hospital facility approved for the purpose of terminating a pregnancy lawfully shall be:

(1) A hospital accredited by the Joint Commission on Accreditation of Hospitals; or

(2) Any other hospital licensed under chapter 70.41 RCW: PROVIDED, That such licensed hospital meets, at a minimum, the standards set forth in these regulations with the exception of Section 10 (1), (8), and (9).

Section 100 NON-HOSPITAL FACILITIES APPROVED FOR TERMINATING PREGNANCY. Any facility not an integral organizational part of an accredited or licensed hospital and not located within its premises, must meet the following requirements to be approved for termination of pregnancy.

(1) Has an agreement with an accredited or licensed hospital for medical consultation and for the transfer of patients in need of immediate hospitalization because of medical emergencies such as hemorrage, shock, perforation or infection, and is located so that it would ordinarily be practical

to transport a patient from the outpatient facility to a hospital in ten minutes or less.

Has a surgical operating room with a minimum dimension of at least ten feet and a minimum area of at least one hundred and twenty square feet; which must be well-lighted, with adequate illumination; with a suction outlet or suction machine, an oxygen outlet or oxygen tank, intravenous stand, a resucitator, storage for surgical supplies, and equipment for collection of surgical linens and wastes.

Has adequate facilities available for patients for short periods of rest and recuperation and due regard to the patient's dignity and privacy.

Has sufficient sanitary toilet facilities for patients within the premises of the facility.

Has a soiled area which includes a clinic service sink, a work-counter, a double compartment sink, storage cabinet and adequate space for linen hampers and waste containers. Soiled areas shall be separated from clean areas by a physical barrier.

Has an autoclave, with a recording thermometer, of sufficient size to accomodate medical supplies and equipment to be sterilized. If the practice of sterilizing unwrapped trays of instruments and other equipment is followed, the autoclave must be located to provide direct access to the operating room from the autoclave. The autoclave may be in either a clean or soiled room area wherein the arrangement and workflow is such that separation of contaminated items from sterile items is maintained.

There shall be sufficient storage units and clean areas to provide for storage of linens, drugs, anesthesia, solutions, instruments, utensils and other clean or sterile supplies and equipment.

No pregnancy more than ten weeks after conception may be terminated in such a facility.

Flammable anesthesia shall not be used in any terminations.

) Each patient receiving services within the facility shall be under the care of a physician. Administration of anesthesia to the patient shall be by a physician or a certified registered nurse anesthetist.

(11) A patient who has undergone a procedure which is producing hemorrhage, shock, respiratory depression or other serious complication shall be transferred to a hospital, when in the judgment of the attending physician, it is deemed medically feasible. All other patients shall be retained in a recovery unit for a period of observation and care until it has been determined that the patient's condition has stabilized to a point where she may be released without jeopardy to her health and safety.

(12) The secretary may modify or exempt an applicant from one or more of the requirements of this section when in his judgment, the well-being and safety of patients would not be jeopardized thereby: PROVIDED, That such action is taken only after thorough inspection and evaluation of all relevant circumstances and conditions.

Section 110 DISCLOSURE OF INFORMATION. Information received by the board or the department through filed reports, inspections or as otherwise authorized, shall not be disclosed publicly in such a manner as to identify any individual without her consent, except by subpoena, nor in such manner as to identify any facility except in a proceeding involving issues of certificates of approval.

Section 120 REPORTING OF PREGNANCY TERMINATIONS. In order for the board and the department to evaluate the effect of the board's rules and regulations in assuring safe and adequate care and treatment of patients, each hospital where lawful abortions are performed in accordance with chapter 3, Laws of 1970, and these rules and regulations shall, on forms prescribed and supplied by the secretary, report to the department during the following month the number and dates of abortions performed during the previous month, giving for each abortion the age and marital status of the patients, the duration of the pregnancy, the method of abortion, any complications such as perforations, infections, and incomplete evacuations, the name of the physician performing the abortion and such other relevant information as may be required by the secretary. All physicians performing abortions in other facilities approved for that purpose shall report in the same manner. All physicians performing abortions in non-approved facilities, when the physician has determined that termination of the pregnancy was immediately necessary to meet a medical emergency shall also report in the same manner, and shall additionally provide a clear and detailed statement of the facts upon which he based his judgment of medical emergency.

OR COPY

Section 130 REVIEW OF REGULATIONS. These regulations shall be reviewed and evaluated on or before six months from this date: December 10, 1970.

Section 140 EMERGENCY SECTION. (Regulations to be effective immediately.)

##

Item No. 8

THE AMERICAN COLLEGE
OF OBSTETRICIANS AND GYNECOLOGIS
79 West Monroe Street • Chicago, Illinois 60603
Telephone 312-236-6814

POLICY ON ABORTION

Policies covering abortions should be designed by the medical staff to safeguard the patient's health or improve her family life situation. They should have due regard for local legal statutes and judicial decrees. Abortion should only be performed in facilities that are administered by a hospital approved by the Joint Commission on Accreditation of Hospitals and/or licensed by a state or province.

It is recognized that abortion may be performed at a patient's request, or upon a physician's recommendation. No physician should be required to perform, nor should any patient be forced to accept an abortion.

When abortion is requested by a patient, the request should be obtained in writing from the patient, or, in the case of a minor, from her parent or guardian. The patient should be informed of the medical nature of the procedure and of its potential consequences. When abortion is recommended by a physician, the indications should be stated in the patient's record, and informed consent obtained from the patient and her husband, or herself if she is unmarried, or from her nearest relative or guardian if she is under the age of consent. When abortion is requested by a patient, a consultation is not necessary. When abortion is recommended by a physician, the indication for the procedure should be approved by a consultant knowledgeable in regard to the condition thought to indicate abortion.

Abortion is an operative procedure and should only be performed: (1) by a physician who has hospital privileges for the care of obstetric-gynecologic patients and (2) in a hospital-facility adequately equipped to care properly for unexpected complications.

In order to assure that adequate facilities will be available for indicated care of other obstetric-gynecologic patients in some communities, consideration should be given by hospitals to (1) providing a room or entirely separate facilities where abortion can be performed with minimal disruption of other hospital procedures and the hospital based educational program, and (2) utilizing hospital personnel who volunteer to care for patients admitted to be aborted.

Approved by the Executive Board
August 1970

p.23

THE AMERICAN PUBLIC HEALTH ASSOCIATION, INC
NEW YORK WASHINGTON SAN FRANCISCO BIRMINGHAM
1740 BROADWAY, NEW YORK, N. Y. 10019 Phone: (212) 245-8000

RECOMMENDED STANDARDS FOR ABORTION SERVICES

I. INTRODUCTION:

Since 1967, 15 states have responded to the increasing public demand for changes in the legal restriction of abortion practice by passing new laws. Moreover, at least 14 states have had the constitutionality of their abortion laws challenged in court. Public health agencies must be prepared, therefore, to respond to an increasing need for abortion services.

Abortion services are an integral part of comprehensive family planning and maternal and child health care. As such, abortion and contraceptive counseling and services should be available together.

Contraception should be encouraged as a means of minimizing the need for abortion. Counseling and services for abortion and contraception should receive full administrative and financial support as part of maternal and child health programs.

When there is a large demand for a service that is in limited supply, a situation exists in which human needs can be exploited for economic gain. The public interest requires that health agencies recognize this fact and make very effort to provide safe, accessible abortion services at reasonable fees for all who are in need of such services.

I. SPECIFIC RECOMMENDATIONS:

A. Referral and Counseling

1. Abortion referral services should be available through state and local health departments, in collaboration with medical societies and voluntary agencies. These services should make both private and public care known and available to women seeking abortion.

2. Counseling is an integral part of abortion services. The manner in which referral and counseling are carried out plays a major role in determining whether the abortion patient is treated in a safe, humane and dignified manner, and protected against exploitation.

3. The APHA therefore recommends the following five standards:

   a. Rapid and simple abortion referral must be readily available through state and local public health departments, medical societies, or other nonprofit organizations.

   b. An important function of counseling should be to simplify and expedite the provision of abortion services; it should not delay the obtaining of these services.

   c. Psychiatric consultation should not be mandatory. As in the case of other specialized medical services psychiatric consultation should be sought for

definite indications and not on a routine basis.

d. A wide range of individuals from appropriately trained, sympathetic volunteers to highly skilled physicians may qualify as abortion counselors.

e. Contraception and/or sterilization should be discussed with each abortion patient.

B. Public Education

Education about abortion procedures and services is a public responsibility. Public health agencies should take a leadership role in providing information to the public. They should educate the public so that there is a general awareness of the current status concerning a woman's legal right to abortion, and so that women desiring abortion know of the circumstances under which this procedure is most safely performed. The importance of having an abortion before the end of the third month of pregnancy should be stressed as a safety factor to every woman at risk of pregnancy who might want to have a pregnancy terminated. Effective education in contraceptive use is an essential part of an abortion service program and will help women seeking abortion to minimize subsequent unwanted pregnancies.

C. Surgical Care

1. While comprehensive information is not available on all factors determining the risks to life and health

associated with the performance of an abortion, three such factors are recognized as important:

a. the skill of the physician,

b. the environment in which the abortion is performed, and above all

c. the duration of pregnancy, as determined by uterine size and confirmed by menstrual history.

It stands to reason that the risks to a woman having an abortion are smaller when in the hands of a well-trained obstetrician-gynecologist than in the hands of a physician with little training or experience. It is also clear that a well equipped hospital offers a wider range of specialized personnel and equipment to cope with unforeseen difficulties than an office or clinic without such resources. It has been abundantly documented that risks to life and health increase steeply with each additional week of gestation. The factor of gestational age is of overriding importance.

2. The APHA recommends therefore that abortions in the second trimester and early abortions in the presence of pre-existing medical complications be performed in hospitals as in-patient procedures.

3. For pregnancies prior to the end of the 12th week, as measured by gestational size, abortion in the hospital with or without overnight stay is probably the safest

practice. The performance of abortions in an extramural treatment facility, however, is an acceptable alternative to abortion in a hospital provided arrangements exist in advance to admit patients promptly if unforeseen complications develop. Standards for any abortion facility should include the following essentials:

a. An operating table, or conventional gynecologic examining table with accessories, which is located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures.

b. Surgical instruments sufficient in number to permit individual sterilization for each patient and which are adequate to perform conventional cervical dilatation and curettage, and electrically safe equipment for vacuum aspiration.

c. Drugs, parenteral fluid and electrolyte solutions (including plasma volume expander) in sufficient supply for emergency use.

d. Anesthesia equipment, including oxygen and equipment for artificial ventilation and administration of anesthetic gases, and resuscitation equipment.

e. Capability to transfer a patient immediately to an operating room in a hospital.

f. Supporting laboratory equipment and personnel, or immediate access to same, for preoperative and emergency laboratory determinations.

g. Special arrangements for patient emergency care including diagnostic and therapeutic contacts for postoperative follow-up on examination.

4. The APHA is concerned with the high prices charged for abortions in many areas and with the inadequate coverage of these services by Medicaid and private insurance carriers, and by the fact that in many places the burden of performing abortions appears to fall on a minority of physicians. The APHA feels that qualified physicians who do not have religious or philosophic objections to abortions are professionally obliged to make their services available at a reasonable cost.

5. The APHA is also concerned with the hostile and punitive attitudes toward women seeking abortion which are manifested by some members of the health professions and ancillary personnel. Women in need of abortion frequently have requirements for counseling, health education, tenderness, and understanding that are even greater than those of other patients.

6. At present, abortions should be performed by physicians or osteopaths who are licensed to practice in their state.

Abortions performed in hospitals should be carried out with adherence to the policies established by the chief of the hospital staff or his delegate.

7. Physicians doing abortions should have adequate training. Such training should be available to all physicians doing abortions. Abortion training should be a part of medical school education and residency training in obstetrics and gynecology and family practice.

8. New developments in the delivery of abortion services and techniques need to be explored in a way that is consonant with the same safeguards which govern all other research involving human subjects.

D. Reporting

1. Reporting of abortions performed is essential to planning for, providing, and improving abortion services. State health departments should assume the responsibility for collecting abortion reports, delegating the responsibility and authority to local health departments when appropriate. The collection of state data nationally is essential to national health planning by the federal government.

2. Confidentiality is essential to abortion reporting. Medical records must identify individuals, but reports to state and local health departments need not do so.

3. The following items are recommended for inclusion in an abortion reporting system:

   a. Date of abortion.

   b. Place of abortion (city and state).

   c. Type of facility (hospital, extramural clinic, doctor's office, other).

   d. Gestational age.

   e. Age of woman.

   f. Ethnic group.

   g. Technique of abortion.

   h. Type of care (inpatient, outpatient).

   i. Residence of woman.

   j. Number of prior pregnancies.

   k. Number of prior deliveries (20 weeks or more) (live birth + fetal deaths).

   l. Number of prior abortions (under 20 weeks)- spontaneous or induced.

   m. Marital status.

   n. Education (years of schooling).

November 1970

BLEED THROUGH POOR COPY

Item No. 10

ABORTION

The AMA policy regarding abortion as determined by its House of Delegates, June 25, 1970 is:

> Whereas, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demands; and
>
> Whereas, The standards of sound clinical judgment, which together with informed patient consent should be determinative according to the merits of each individual case; therefore be it
>
> *Resolved,* That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital after consultation with two other physicians chosen becuase of their professional competency, acting only in conformance with standards of good medical practice and within the Medical Practice Act of his State; and be it further
>
> *Resolved,* That no physician or other professional personnel shall be compelled to perform any act which violates his good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally-held moral principles. In these circumstances good medical practice requires only that the physician or other professional personnel withdraw from the case so long as the withdrawal is consistent with good medical practice.

- -

The AMA's Judicial Council said:

> "The Judicial Council is charged with interpreting the Principles of Medical Ethics as adopted by the House of Delegates of the AMA.
>
> The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.
>
> In the matter of abortions, as of any other medical procedure, the Judicial Council becomes involved whenever there is alleged violation of the Principles of Medical Ethics as established by the House of Delegates."

Item No. 11

TEXT OF THE CONSTITUTION OF THE WORLD HEALTH ORGANIZATION

THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States.

The achievement of any State in the promotion and protection of health is of value to all. Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger.

Healthy development of the child is of basic importance; the ability to live harmoniously in a changing total environment is essential to such development.

The extension to all peoples of the benefits of medical, psychological and related knowledge is essential to the fullest attainment of health.

Informed opinion and active co-operation on the part of the public are of the utmost importance in the improvement of the health of the people.

Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures.

ACCEPTING THESE PRINCIPLES, and for the purpose of co-operation among themselves and with others to promote and protect the health of all peoples, the Contracting Parties agree to the present Constitution and hereby establish the World Health Organization as a specialized agency within the terms of Article 57 of the Charter of the United Nations.

Item No. 12

NARAL
NATIONAL ASSOCIATION FOR REPEAL OF ABORTION LAWS
250 WEST 57TH STREET
NEW YORK, N.Y. 10019

NATIONAL ORGANIZATIONS RECOMMENDING REPEAL OF ABORTION LAWS

American Association of Planned Parenthood Physicians
American Baptist Convention
American Civil Liberties Union
American College of Obstetricians & Gynecologists
Americans for Democratic Action
American Ethical Union
American Friends Service Committee
American Humanist Association
American Jewish Congress
American Medical Women's Association
American Protestant Hospital Association
American Psychiatric Association
American Psychoanalytic Association
American Psychological Association
American Public Health Association
Association for Voluntary Sterilization
Church Women United, Board of Managers
Citizen's Advisory Council on the Status of Women
Clergy Consultation Service on Abortion
Episcopal Churchwomen of the U. S. A.
Federation of American Scientists
Group for the Advancement of Psychiatry
Izaak Walton League
Medical Committee for Human Rights
Moravian Church, Northern Province Synod
National Association for Repeal of Abortion Laws
National Committee for Children & Youth
National Council of Jewish Women
National Council of Obstetrics-Gynecology
National Council of Women of the United States
National Emergency Civil Liberties Committee
National Medical Association
National Organization for Women
Physicians Forum
Planned Parenthood-World Population
President's Task Force on the Mentally Handicapped
Student American Medical Association
Unitarian Universalist Association
Unitarian Universalist Women's Federation
United Automobile Workers Union
United Church of Christ, United Church Board for Homeland Ministries
United Methodist Church
United Presbyterian Church in the U. S. A., Board of Christian Education
Women's Division of the United Methodist Church
Women's Liberation
Young Women's Christian Association of the U. S. A.
Zero Population Growth, Inc.

In addition, organizations in each state have declared support for repeal. For example, the following joined the recent effort to repeal Hawaii's abortion law:

American Association of University Women, Hawaii Chapter
American Civil Liberties Union of Hawaii
Associated Students of the University of Hawaii
Chamber of Commerce of Hawaii
Chamber of Commerce of Maui
Child and Family Service
Clergy Counseling Service
Commission on Children and Youth
Committee for Protection of Children
Democratic Action Group
Department of Social Services
Episcopal Diocese of Hawaii
Hawaii Council of Churches
Hawaii Government Employees Association
Hawaii Island Chamber of Commerce
Hawaii Medical Association
Hawaii Planned Parenthood
Hawaii Psychiatric Society
Hawaii Psychological Association
Hawaii Public Health Association
Hawaii State Federation of Labor, A.F.L.-C.I.O.
I. L. G. W. U., Local 142
John Howard Association
Kappa Delta Sorority Alumnae Association
Kilohana United Methodist Church
Mental Health Association of Hawaii
National Association of Social Workers, Hawaii Chapter
Salvation Army, Hawaiian Headquarters
Sierra Club of Hawaii
Unitarian Church
University Abortion & Birth Control Committee
Volunteers from VISTA
Zero Population Growth, Inc., Hawaii Chapter

II.

FEDERAL AND STATE COURT DECISIONS

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch.	On Appeal From the United States District Court for the District of Columbia.

[April 21, 1971]

Mr. Justice Black delivered the opinion of the Court.*

Appellee Milan Vuitch, a licensed physician, was indicted in the United States District Court for the District of Columbia for producing and attempting to produce abortions in violation of 22 D. C. Code 201. Before trial, the district judge granted Vuitch's motion to dismiss the indictments on the ground that the District of Columbia abortion law was unconstitutionally vague. 305 F. Supp. 1032 (DCDC 1969). The United States appealed to this Court under the Criminal Appeals Act, 18 U. S. C. § 3731. We postponed decision on jurisdiction to the hearing on the merits, 397 U. S. 1061, and requested the parties to brief and argue specified questions on that issue. 399 U. S. 923. We hold that we have jurisdiction and that the statute is not unconstitutionally vague. We reverse.

I

The first question is whether we have jurisdiction under the Criminal Appeals Act to entertain this direct appeal from the United States District Court for the

*The Chief Justice, Mr. Justice Douglas, Mr. Justice Stewart, and Mr. Justice White join in Part I of this opinion. The Chief Justice, Mr. Justice Harlan, Mr. Justice White, and Mr. Justice Blackmun join in Part II of this opinion.

District of Columbia. That Act [1] gives us jurisdiction over direct appeals from district court judgments "in all criminal cases . . . dismissing any indictment where such decision is based upon the invalidity . . . of the statute upon which the indictment is founded." 18 U. S. C. § 3731. The decision appealed from is a dismissal of an indictment on the ground that the District of Columbia abortion law, on which the indictment was based, is unconstitutionally vague. This abortion statute, 22 D. C. Code 201, is an Act of Congress applicable only in the District of Columbia and we suggested that the parties argue whether a decision holding unconstitutional such a statute is appealable directly to this Court under the Criminal Appeals Act. The literal wording of the Act plainly includes this statute, even though it applies only to the District. A piece of legislation so limited is nevertheless a "statute" in the sense that it was duly enacted into law by both Houses of Congress and was signed by the President. And the Criminal Appeals Act contains no language that purports to limit or qualify the term "statute." On the contrary, the Act authorizes government appeals from district courts to the Supreme Court in *"all criminal cases"* where a district court judgment dismissing an indictment is based upon the invalidity of the statute on which the indictment is founded.

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[1] The Act states in pertinent part:

"An appeal may be taken by and on behalf of the United States from the district courts direct to the Supreme Court of the United States in all criminal cases in the following instances:

"From a decision or judgment setting aside, or dismissing any indictment or information, or any count thereof, where such decision of judgment is based upon the invalidity or construction of the statute upon which the indictment or information is founded. . . ." 18 U. S. C. § 3731.

An examination of the legislative history of the Criminal Appeals Act and its amendments suggests no reason why we should depart from the Act's literal meaning and exclude D. C. statutes from its coverage. The committee reports and floor debates contain no discussion indicating that the term "statute" does not include statutes applicable only to the District of Columbia.[2] We therefore conclude that we have jurisdiction over this appeal under the Criminal Appeals Act.

Our Brother HARLAN has argued in dissent that we do not have jurisdiction over this direct appeal. He suggests that such a result is supported by the decision in *United States* v. *Burroughs*, 289 U. S. 159 (1933), the policy underlying the Criminal Appeals Act, and the canon of construction that statutes governing direct appeals to this Court should be strictly construed.

It is difficult to see how the *Burroughs* decision lends much force to his argument, since that case held only that the term "district court" in the Criminal Appeals Act did not include the then-existing Supreme Court of the District of Columbia. *Id.*, at 163–164. The dissent goes on to suggest the Act should be construed in light of the Congressional purpose of "avoiding inconsistent enforcement of criminal laws." *Post*, at 12. This purpose would not be served by our refusing to decide this case now after it has been orally argued. In the last several years, abortion laws have been repeatedly attacked as unconstitutionally vauge in both state and federal courts with widely varying results. A number of these cases are now pending on our docket. A refusal to accept jurisdiction here would only compound confusion for doctors,

[2] See H. Conf. Rep. No. 8113, 59th Cong., 2d Sess.; H. R. Rep. No. 2119, 59th Cong., 1st. Sess.; H. R. Rep. No. 45 and S. Rep. No. 868, 77th Cong., 1st. Sess.; H. Conf. Rep. No. 2052, 77th Cong., 2d Sess.

their patients, and law enforcement officials. As this case makes abundantly clear, a ruling on the validity of a statute applicable only to the District can contribute to great disparities and confusion in the enforcement of criminal laws. Finally, my Brother HARLAN'S dissent also appears to rely on the fact that this Court has never accepted jurisdiction over a direct appeal under the Criminal Appeals Act involving the validity of a District of Columbia statute. *Post*, at 13. Since this Court has never either accepted or rejected jurisdiction of such an appeal, it is difficult to see how the complete absence of precedent in this Court lends any weight whatever to his argument. Neither previous cases nor the purpose behind the Criminal Appeals Act provides any satisfactory reason why the term "statute" should not include those statutes applicable only in the District of Columbia.

One other procedural problem remains. We asked the parties to brief the question whether the Government could have appealed this case to the Court of Appeals for the District of Columbia under 23 D. C. Code 105, and, if so, whether we should refuse to entertain the appeal here as a matter of sound judicial administration. That D. C. Code provision states:

> "In all criminal prosecutions the United States . . . shall have the same right of appeal that is given to the defendant . . . ."

The relationship between the Criminal Appeals Act and this Code section was considered in *Carroll* v. *United States*, 354 U. S. 394, 411, where the Court concluded:

> "[C]riminal appeals by the Government in the District of Columbia are not limited to the categories set forth in 18 U. S. C. 3731 [the Criminal Appeals Act], although as to cases of the type covered by that special jurisdictional statute its explicit direc-

> tions will prevail over the general terms of [23 D. C. Code 105]."

Since we have concluded above that this appeal is covered by the Criminal Appeals Act, it would seem to follow from *Carroll* that the Act's provisions control and no appeal could have been taken to the Court of Appeals. Although *Carroll* seems to be dispositive, it has been suggested that it may now be limited by *United States* v. *Sweet*, 399 U. S. 517 (1970), which contains some language suggesting that the Government may be empowered to take an appeal to the Court of Appeals under 23 D. C. Code 105, even when a direct appeal would be proper here under the Criminal Appeals Act. *Id.*, at 518. We do not elaborate upon that suggestion. We only hold that once an appeal is properly here under the Criminal Appeals Act, we should not refuse to consider it because it might have been taken to another court.

II

We turn now to the merits. Appellee Milan Vuitch was indicted for producing and attempting to produce abortions in violation of 22 D. C. Code 201. That Act provides in part:

> "Whoever, by means of any instrument, medicine, drug or other means whatever, procures or produces or attempts to procure or produce an abortion or miscarriage on any woman, unless the same were done as necessary for the preservation of the mother's life or health and under the direction of a competent licensed practitioner of medicine, shall be imprisoned in the penitentiary not less than one year or not more than ten years; . . ."

Without waiting for trial, the District Judge dismissed the indictment on the ground that the abortion statute

was unconstitutionally vague. In his view, set out substantially in full below,[3] the statute was vague for two principal reasons:

1. The fact that once an abortion was proved a physician "is presumed guilty and remains so unless a jury

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[3] The District Judge stated:

". . . It is suggested that these words [as necessary for the preservation of the mother's life or health] are not precise; that, as interpreted, they improperly limit the physician in carrying out his professional responsibilities; and that they interfere with a woman's right to avoid childbirth for any reason. The word "health" is not defined and in fact remains so vague in its interpretation and the practice under the act that there is no indication whether it includes varying degrees of mental as well as physical health. While the law generally has been careful not to interfere with medical judgment of competent physicians in treatment of individual patients, the physician in this instance is placed in a particularly unconscionable position under the conflicting and inadequate interpretations of the D. C. abortion statute now prevailing. The Court of Appeals established by such early cases as *Peckham* v. *United States*, 96 U. S. App. D. C. 312 (1955), *cert. denied*, 350 U. S. 912, and *Williams* v. *United States*, 78 U. S. App. D. C. 147 (1943), that upon the Government establishing that a physician committed an abortion, the burden shifted to the physician to justify his acts. In other words, he is presumed guilty and remains so unless a jury can be persuaded that his acts were necessary for the preservation of the woman's life or health. These holdings, which may well offend the Fifth Amendment of the Constitution, as interpreted in recent decisions such as *Leary* v. *United States*, 395 U. S. 89 Sup. Ct. 1532, 23 L. Ed. 2d 658 (1965), and *United States* v. *Gainey*, 380 U. S. 63, 85, Sup. Ct. 754, 13 L. Ed. 2d 658 (1965), also emphasize the lack of necessary precision in this criminal statute. The jury's acceptance or nonacceptance of an individual doctor's interpretation of the ambivalent and uncertain word 'health' should not determine whether he stands convicted of a felony, facing ten years' imprisonment. His professional judgment made in good faith should not be challenged. There is no clear standard to guide either the doctor, the jury or the Court. No body of medical knowledge delineates what degree of mental or physical health or combination of the two is required to make an abortion conducted by a competent physician legal or illegal under the Code. . . ." 305 F. Supp. 1032, at 1034.

can be persuaded that his acts were necessary for the preservation of the woman's life or health."

2. The presence of the "ambivalent and uncertain word 'health.'"

In concluding that the statute places the burden of persuasion on the defendant once the fact of an abortion has been proved,[4] the court relied on *Williams* v. *United States*, 138 F. 2d 81 (CADC 1943). There the Court of Appeals for the District of Columbia held that the prosecution was not required to prove as part of its case in chief that the operation was not necessary to preserve life or health. *Id.*, at 81, 83. The court indicated that once the prosecution established that an abortion had been performed the defendant was required "to come forward with evidence which with or without other evidence is sufficient to create reasonable doubt of guilt." *Id.*, at 84. The District Court here appears to have read *Williams* as holding that once an abortion is proved, the burden of persuading the jury that it was legal (*i. e.*, necessary to the preservation of the mother's life or health) is cast upon the physician. Whether or not this is a correct reading of *Williams*, we believe it is an erroneous interpretation of the statute. Certainly a statute that outlawed only a limited category of abortions but "presumed" guilt whenever the mere fact of abortion was established, would at the very least present serious constitutional problems under this Court's previous decision interpreting the Fifth Amendment. *Tot* v. *United States*, 319 U. S. 463 (1943); *Leary* v. *United States*, 395 U. S. 6, 36 (1969). But of course statutes should be construed whenever possible so as to uphold their constitutionality.

[4] The trial court also cited *Peckham* v. *United States*, 226 F. 2d 34 (CADC 1955), as dealing with the D. C. abortion law. However, the opinion in that case does not discuss the burden of proof under the statute.

The statute does not outlaw all abortions, but only those which are not performed under the direction of a competent, licensed physician, and those not necessary to preserve the mother's life or health. It is a general guide to the interpretation of criminal statutes that when an exception is incorporated in the enacting clause of a statute, the burden is on the prosecution to plead and prove that the defendant is not within the exception. When Congress passed the District of Columbia abortion law in 1901 and amended it in 1953, it expressly authorized physicians to perform such abortions as are necessary to preserve the mother's "life or health." Because abortions were authorized only in more restrictive circumstances under previous D. C. law, the change must represent a judgment by Congress that it is desirable that women be able to obtain abortions needed for the preservation of their lives or health.[5] It would be highly anomalous for a legislature to authorize abortions necessary for life or health and then to demand that a doctor, upon pain of one to ten years' imprisonment, bear the burden of proving that an abortion he performed fell within that category. Placing such a burden of proof on a doctor would be peculiarly inconsistent with society's notions of the responsibilities of the medical profession. Generally, doctors are encouraged by society's expectations, by the strictures of malpractice law and by their own professional standards to give their patients such treatment as is necessary to preserve their health. We are unable to believe that Congress intended that a physician be required to prove his innocence. We therefore hold that under 22 D. C. Code 201, the burden is on

[5] Before 1901 the existing statute allowed abortion only "for the purpose of preserving the life of any woman pregnant . . . ." Abert, The Compiled Statutes in Force in the District of Columbia, c. XVI, pp. 158–159 (1894).

the prosecution to plead and prove than an abortion was not "necessary for the preservation of the mother's life or health."

There remains the contention that the word "health" is so imprecise and has so uncertain a meaning that it fails to inform a defendant of the charge against him and therefore the statute offends the Due Process Clause of the Constitution. See, *e. g.*, *Lanzetta* v. *New Jersey*, 306 U. S. 451 (1939). We hold that it does not. The trial court apparently felt that the term was vague because there "is no indication whether it includes varying degrees of mental as well as physical health." 305 F. Supp. 1032, at 1034. It is true that the legislative history of the statute gives no guidance as to whether "health" refers to both a patient's mental and physical state. The term "health" was introduced into the law in 1901 when the statute was enacted in substantially its present form. The House Report[*] on the bill contains no discussion of the term "health" and there was no Senate report. Nor have we found any District of Columbia cases prior to this district court decision that shed any light on the question. Since that decision, however, the issue has been considered in *Doe* v. *General Hospital of the District of Columbia*, 313 F. Supp. 1170 (DCDC 1970). There District Judge Waddy construed the statute to permit abortions "for mental health reasons whether or not the patients had a previous history of mental defects." *Id.*, at 1174–1175. The same construction was followed by the United States Court of Appeals for the District of Columbia in further proceedings in the same case. *Doe* v. *General Hospital of the District of Columbia*, 434 F. 2d 423; 434 F. 2d 427 (CADC 1970). We see no reason why this interpretation of the statute should not

[*] H. R. Rep. No. 1017, 56th Cong., 1st Sess.

be followed. Certainly this construction accords with the general usage and modern understanding of the word "health," which includes phychological as well as physical well-being. Indeed Webster's Dictionary, in accord with that common usage, properly defines health as "the state of being sound in body or mind." Viewed in this light, the term "health" presents no problem of vagueness. Indeed, whether a particular operation is necessary for a patient's physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered.[7]

We therefore hold that properly construed the District of Columbia abortion law is not unconstitutionally vague, and that the trial court erred in dismissing the indictments on that ground. Appellee has suggested that there are other reasons why the dismissal of the indictment should be affirmed. Essentially, these arguments are based on this Court's decision in *Griswold* v. *Connecticut*, 381 U. S. 479 (1965). Although there was some reference to these arguments in the opinion of the court below, we read it as holding simply that the statute was void for vagueness because it failed in that court's language to "give that certainty which due process of law considers essential in a criminal statute." 305 F. Supp. 1032, at 1034. Since that question of vagueness was the only issue passed upon by the District Court it is the

[7] Our Brother DOUGLAS appears to fear that juries might convict doctors in any abortion case simply because some jurors believe all abortions are evil. Of course such a danger exists in all criminal cases, not merely those involving abortions. But there are well-established methods defendants may use to protect themselves against such jury prejudice: continuances, changes of venue, challenges to prospective jurors on *voir dire*, and motions to set aside verdicts which may have been produced by prejudice. And of course a court should always set aside a jury verdict of guilt when there is not evidence from which a jury could find a defendant guilty beyond a reasonable doubt.

only issue we reach here. *United States* v. *Borden Co.*, 308 U. S. 188 (1939); *United States* v. *Petrillo*, 332 U. S. 1 (1947); *United States* v. *Blue*, 384 U. S. 251, 256 (1966).

The judgment is reversed and the case remanded for further proceedings not inconsistent with this opinion.

Reversed.

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch.	On Appeal From the United States District Court for The District of Columbia.

[April 21, 1971]

Mr. Justice White, concurring.

I join the Court's opinion and judgment. As to the facial vagueness argument, I have these few additional words. This case comes to us unilluminated by facts or record. The District Court's holding that the District of Columbia statute is unconstitutionally vague on its face because it proscribes all abortions except those necessary for the preservation of the mother's life or health was a judgment that the average person could not understand which abortions were permitted and which were prohibited. But surely the statute puts everyone on adequate notice that the health of the mother, whatever that phrase means, was the governing standard. It should also be absolutely clear that a doctor is not free to perform abortions on request without considering whether the patient's health required it. No one of average intelligence could believe that under this statute abortions not dictated by health considerations are legal. Thus even if the "health" standard were unconstitutionally vague, which I agree is not the case, the statute is not void on its face since it reaches a class of cases in which the meaning of "health" is irrelevant and no possible vagueness problem could arise. We do not, of course, know whether this is one of those cases. Until we do facial vagueness claims must fail. Cf. *United States* v. *National Dairy Corp.*, 372 U. S. 29 (1963).

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch. | On Appeal From the United States District Court for the District of Columbia.

[April 21, 1971]

Mr. Justice Douglas, dissenting in part.

While I agree with Part I of the Court's opinion that we have jurisdiction over this appeal, I do not think the statute meets the requirements of procedural due process.

The District of Columbia Code makes it a felony for a physcian to perform an abortion "unless the same were done as necessary for the preservation of the mother's life or health." 22 D. C. Code 201.

I agree with the Court that a physician—within the limits of his own expertise—would be able to say that an abortion at a particular time performed on a designated patient would or would not be necessary for the "preservation" of her "life or health." That judgment, however, is highly subjective, dependent on the training and insight of the particular physician and his standard as to what is "necessary" for the "preservation" of the mother's "life or health."

The answers may well differ, physician to physician. Those trained in conventional obstetrics may have one answer; those with deeper psychiatric insight may have another. Each answer is clear to the particular physician. If we could read the Act as making that determination conclusive, not subject to review by judge and by jury, the case would be simple, as Mr. Justice Stewart points out. But that does such violence to the statutory

scheme that I believe it is beyond the range of judicial interpretation so to read the Act. If it is to be revised in that manner, Congress should do it.

Hence I read the Act, as did the District Court, as requiring submission to court and jury of the physician's decision. What will the jury say? The prejudices of jurors are customarily taken care of by challenges for cause and by preemptory challenges. But vagueness of criminal statutes introduces another element that is uncontrollable. Are the concepts so vague that possible offenders have no safe guidelines for their own action? Are the concepts so vague that jurors can give them a gloss and meaning drawn from their own predilections and prejudices? Is the statutory standard so easy to manipulate that although physicians can make good-faith decisions based on the standard, juries can nonetheless make felons out of them?

The Court said in *Lanzetta* v. *New Jersey*, 306 U. S. 451, 453, that a ". . . statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process."

A three-judge court in evaluating a Texas statutory standard as to whether an abortion was attempted "for the purpose of saving the life of the mother" said:

> "How *likely* must death be? Must death be certain if the abortion is not performed? Is it enough that the woman could not undergo birth without an ascertainably higher possibility of death than would normally be the case? What if the woman threatened suicide if the abortion was not performed? How *imminent* must death be if the abortion is not performed? Is it sufficient if having the child will shorten the life of the woman by a number of years?" *Roe* v. *Wade*, 314 F. Supp. 1217, 1223.

The *Roe* case was followed by a three-judge court in *Doe* v. *Scott*, — F. Supp. —, which struck down an Illinois statute which sanctioned an abortion "necessary for the preservation of a woman's life." And see *People* v. *Belous*, 71 Cal. 2d 954, 458 Pac. 2d 194.

A doctor may well remove an appendix far in advance of rupture in order to prevent a risk that may never materialize. May he do the same under this abortion statute?

May he perform abortions on unmarried woman who want to avoid the "stigma" of having an illegitimate child? Is bearing a "stigma" a "health" factor? Only in isolated cases? Or is it such whenever the woman is unmarried?

Is any unwanted pregnancy a "health" factor because it is a source of anxiety?

Is an abortion "necessary" in the statutory sense if the doctor thought that an additional child in a family would unduly tax the mother's physical well-being by reason of the additional work which would be forced upon her?

Would a doctor be violating the law if he performed an abortion because the added expense of another child in the family would drain its resources, leaving an anxious mother with an insufficient budget to buy nutritious food?

Is the fate of an unwanted child or the plight of the family into which it is born relevant to the factor of the mother's "health?"

Mr. Justice Holmes, in holding that "unreasonable" restraint of trade was an adequate constitutional standard of criminality, said in *Nash* v. *United States*, 229 U. S. 373, 377, that "the law is full of instances where a man's fate depends on his estimating rightly, that is, as the jury subsequently estimates it, some matter of degree. If his judgment is wrong, not only may he

incur a fine or a short imprisonment, as here; he may incur the penalty of death."

He wrote in a context of economic regulations which are restrained by few, if any, constitutional guarantees.

Where, however, constitutional guarantees are implicated, the standards of certainty are more exacting.

Winters v. *New York*, 333 U. S. 507, 514, 519, held void-for-vagueness a state statute which as construed made it a crime to print stories of crime "so massed as to incite to crime," since such a regulatory scheme trenched on First Amendment rights of the press.

The standard of "sacrilegious" can be used in such accordion-like way as to infringe on religious rights protected by the First Amendment. *Joseph Burstyn, Inc.* v. *Wilson*, 343 U. S. 495, 505.

The requirement of a "narrowly drawn" statute when the regulation touches a protected constitutional right (*Cantwell* v. *Connecticut*, 310 U. S. 296, 311; *Thornhill* v. *Alabama*, 310 U. S. 88, 100) is only another facet of the void-for-vagueness problem.

What the Court held in *Herndon* v. *Lowry*, 301 U. S. 242, is extremely relevant here. The ban of publications made to incite insurrection was held to suffer the vice of vagueness:

> "The statute, as construed and applied in the appellant's trial, does not furnish a sufficiently ascertainable standard of guilt. . . . Every person who attacks existing conditions, who agitates for a change in the form of government, must take the risk that if a jury should be of opinion he ought to have foreseen that his utterances might contribute in any measure to some future forcible resistance to the existing government he may be convicted of the offense of inciting insurrection. . . . *The law, as*

thus construed, licenses the jury to create its own standard in each case." *Id.*, 261, 262, 263. (Italics added.)

If these requirements of certainty are not imposed then the triers of fact have "a power to invade imperceptibly (and thus unreviewably) a realm of constitutionally protected personal liberties." Amsterdam, The Void-For-Vagueness Doctrine in the Supreme Court, 109 U. Pa. L. Rev. 67, 104 (1960).

Abortion touches intimate affairs of the family, of marriage, of sex, which in *Griswold* v. *Connecticut*, 381 U. S. 479, we held to involve rights associated with several express constitutional rights and which are summed up in "the right of privacy." They include the right to procreate (*Skinner* v. *Oklahoma*, 316 U. S. 535), the right to marry across the color line (*Loving* v. *Virginia*, 388 U. S. 1), the intimate familial relations between children and parents (*Meyer* v. *Nebraska*, 262 U. S. 390; *Levy* v. *Louisiana*, 391 U. S. 68, 71–72). There is a compelling personal interest in marital privacy and in the limitation of family size. And on the other side is the belief of many that the fetus, once formed, is a member of the human family and that mere personal inconvenience cannot justify his destruction. This is not to say that government is powerless to legislate on abortions. Yet the laws enacted must not trench on constitutional guarantees which they can easily do unless closely confined.

Abortion statutes deal with conduct which is heavily weighted with religious teachings and ethical concepts.[1]

[1] "There remains the moral issue of abortion as murder. We submit that this is insoluble, a matter of religious philosophy and religious principle and not a matter of fact. We suggest that those who believe abortion is murder need not avail themselves of it. On the other hand, we do not believe that such conviction should limit

Mr. Justice Jackson once spoke of the "treacherous grounds we tread when we undertake to translate ethical concepts into legal ones, case by case." *Jordan* v. *De George*, 341 U. S. 223, 242 (dissenting). The difficulty and danger are compounded when religion adds another layer of prejudice.[2] The end result is that juries condemn what they personally disapprove.

The subject of abortions—like cases involving obscenity[3]—is one of the most inflammatory ones to reach

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the freedom of those not bound by identical religious conviction. Although the moral issue hangs like a threatening cloud over any open discussion of abortion, the moral issuses are not all one-sided. The psychoanalyst Erik Erikson stated the other side well when he suggested that 'The most deadly of all possible sins is the mutilation of a child's spirit.' There can be nothing more destructive to a child's spirit than being unwanted, and there are few things more disruptive to a woman's spirit than being forced without love or need into motherhood." VII The Right to Abortion: A Psychiatric View, pp. 218–219 (Group for the Advancement of Psychiatry, 1969).

[2] Mr. Justice Clark recently wrote: "Throughout history religious belief has wielded a vital influence on society's attitude regarding abortion. The religious issues involved are perhaps the most frequently debated aspects of abortion. At the center of the ecclesiastical debate is the concept of 'ensoulment' or 'person-hood,' *i. e.*, the time at which the fetus becomes a human organism. The Reverend Joseph F. Donseel of Fordham University admitted that no one can determine with certainty the exact moment at which 'ensoulment' occurs, but we must deal with the moral problems of aborting a fetus even if it has not taken place. Many Roman Catholics believe that the soul is a gift of God given at conception. This leads to the conclusion that aborting a pregnancy at any time amounts to the taking of a human life and is therefore against the will of God. Others, including some Catholics, believe that abortion should be legal until the baby is viable, *i. e.*, able to support itself outside the womb. In balancing the evils, the latter conclude that the evil of destroying the fetus is outweighed by the social evils accompanying forced pregnancy and childbirth." Religion, Morality and Abortion: A Constitutional Appraisal, 2 Loy. L. Rev. 1, 4 (1969).

[3] I have expressed my views on the vagueness of criminal laws governing obscenity in *Dyson* v. *Stein*, decided February 23, 1971

the Court. People instantly take sides and the public, from whom juries are drawn, makes up its mind one way or the other before the case is even argued. The interests of the mother and the fetus are opposed. On which side should the State throw its weight? The issue is volatile; and it is resolved by the moral code which an individual has. That means that jurors may give it such meaning as they choose, while physicians are left to operate outside the law. Unless the statutory code of conduct is stable and in very narrow bounds, juries have a wide range and physicians have no reliable guideposts. The words "necessary for the preservation of the mother's life or health" become free-wheeling concepts, too easily taking on meaning from the juror's predilections or religious prejudices.

I would affirm the dismissal of this indictment and leave to the experts the drafting of abortion laws [4] that protect good-faith medical practitioners from the treacheries of the present law.

(dissenting opinion). And see the dissent of MR. JUSTICE BLACK in *Ginzburg* v. *United States*, 383 U. S. 463, 477.

[4] Clark, *supra* n. 2, at 10–11.

Cf. New York's new abortion law effective July 1, 1970, 39 McKinney's Consol. L. § 125.05:

"An abortional action is justifiable when committed upon a female with her consent by a duly licensed physician (a) under a reasonable belief that such is necessary to preserve her life, or, (b) within twenty-four weeks from the commencement of her pregnancy. A pregnant female's commission of an abortional act upon herself is justifiable when she acts upon the advice of a duly licensed physician (1) that such act is necessary to preserve her life, or, (2) within twenty-four weeks from the commencement of her pregnancy. The submission by a female to an abortional act is justifiable when she believes that it is being committed by a duly licensed physician, acting under a reasonable belief that such act is necessary to preserve her life, or, within twenty-four weeks from the commencement of her pregnancy." And see Hall, The Truth About Abortion in New York, Columbia Forum, Winter 1970, p. 18; Schwartz, The Abortion Laws, 67 Ohio St. Med. J. 33 (1971).

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch.	On Appeal From the United States District Court for the District of Columbia.

[April 21, 1971]

Mr. Justice Harlan, with whom Mr. Justice Brennan, Mr. Justice Marshall, and Mr. Justice Blackmun join, dissenting as to jurisdiction.

Appellee Vuitch was indicted in the United States District Court for the District of Columbia for violations of 22 D. C. Code 201, the District of Columbia abortion statute. This statute is applicable only within the District of Columbia. On pretrial motion by Vuitch, the indictments were dismissed on the ground that the abortion statute was unconstitutionally vague. The United States appealed directly to this Court under the terms of the Criminal Appeals Act of 1907, 18 U. S. C. § 3731, relying on the provision allowing direct appeal "[f]rom a decision or judgment setting aside, or dismissing any indictment or information, or any count thereof, where such decision or judgment is based upon the invalidity or construction of the statute upon which the indictment or information is founded." [1] It is not contested that, but for this provision of the Criminal Appeals Act, the Government would have a right of appeal to the Court of

[1] The text of 18 U. S. C. § 3731 was as follows:

"An appeal may be taken by and on behalf of the United States from the district courts direct to the Supreme Court of the United States in all criminal cases in the following instances:

"From a decision or judgment setting aside, or dismissing any indictment or information, or any count thereof, where such decision or judgment is based upon the invalidity or construction of the statute upon which the indictment or information is founded.

"From a decision arresting a judgment of conviction for insufficiency of the indictment or information, where such decision is based

Appeals for the District of Columbia under 23 D. C. Code 105, which provides:

"In all criminal prosecutions the United States or the District of Columbia, as the case may be, shall

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upon the invalidity or construction of the statute upon which the indictment or information is founded.

"From the decision or judgment sustaining a motion in bar, when the defendant has not been put in jeopardy.

"An appeal may be taken by and on behalf of the United States from the district courts to a court of appeals in all criminal cases, in the following instances:

"From a decision or judgment setting aside, or dismissing any indictment or information, or any count thereof except where a direct appeal to the Supreme Court of the United States is provided by this section.

"From a decision arresting a judgment of conviction except where a direct appeal to the Supreme Court of the United States is provided by this section.

"The appeal in all such cases shall be taken within thirty days after the decision or judgment has been rendered and shall be diligently prosecuted.

"Pending the prosecution and determination of the appeal in the foregoing instances, the defendant shall be admitted to bail on his own recognizance.

"If an appeal shall be taken, pursuant to this section, to the Supreme Court of the United States which, in the opinion of that Court, should have been taken to a court of appeals, the Supreme Court shall remand the case to the court of appeals, which shall then have jurisdiction to hear and determine the same as if the appeal had been taken to that court in the first instance.

"If an appeal shall be taken pursuant to this section to any court of appeals which, in the opinion of such court, should have been taken directly to the Supreme Court of the United States, such court shall certify the case to the Supreme Court of the United States, which shall thereupon have jurisdiction to hear and determine the case to the same extent as if an appeal had been taken directly to that Court."

As noted in *United States* v. *Weller*, No. 77, October Term 1970 (decided Feb. 24, 1971), these provisions were amended by § 14 (a) of the Omnibus Crime Control Act of 1970, 84 Stat. 1890 (1971). But cases begun in the District Court before the new statute took effect are not affected. See *United States* v. *Weller*, *supra*, at n. 1.

> have the same right of appeal that is given to the defendant, including the right to a bill of exceptions: *Provided*, That if on such appeal it shall be found that there was error in the rulings of the court during a trial, a verdict in favor of the defendant shall not be set aside."

The Court today—relying on the generic reference to "statutes" and "all criminal cases" in the text of 18 U. S. C. § 3731 and the absence of an express exclusion of statutes applicable only within the District of Columbia—concludes that 18 U. S. C. § 3731 rather than 23 D. C. Code 105 provides the proper appellate route for this case. I must disagree.

I

The historical development of the Government's right to appeal in criminal cases both in the District of Columbia and throughout the Nation is surveyed in *Carroll* v. *United States*, 354 U. S. 394 (1957). Section 105 of the D. C. Code was passed in 1901 as § 935 of the Code of 1901. 31 Stat. 1341. Prior to the Criminal Appeals Act of 1907, the Government had no right of appeal in criminal cases outside of the District of Columbia. To remedy this situation, a bill was introduced in the House of Representatives. That bill practically tracked the language of the D. C. statute, and made no provision for direct appeal to this Court. 40 Cong. Rec. 5408. The accompanying House Report described the bill as follows: "The accompanying bill will extend [§ 935] of the code of the District of Columbia to all districts in the United States." H. R. Rep. No. 2119, 59th Cong., 1st Sess., at 2 (1906). That bill passed the House, but the Senate Committee on the Judiciary rejected the House approach of simply extending the provisions of the D. C. appeals statute to the rest of the Nation; the Senate Committee instead substituted a more narrowly drawn measure

which enumerated specific substantive categories of criminal cases to be appealable by the Government and allocated jurisdiction over these appeals between the Supreme Court and the then Circuit Courts of Appeals according to the allocation of appellate jurisdiction for civil cases established in the Circuit Court of Appeals Act of 1891. S. Rep. No. 3922, 59th Cong., 1st Sess. (1906). See *Carroll* v. *United States*, *supra*, at 402 n. 11. Even that bill as narrowed could not pass the Senate; it provoked extended debate in which the opponents of the measure focused on the potential for abuse of individual rights arising from repeated court proceedings, delays in appeals, and restraints on personal freedom while the Government prosecuted its appeal. See generally *United States* v. *Sisson*, 399 U. S. 267 (1970). The upshot of these debates was that Senator Nelson, the bill's floor manager in the Senate, agreed to accept a variety of amendments which further narrowed the categories of cases appealable by the Government and made special provision for the defendant's release on his own recognizance. See 41 Cong. Rec. 2818–2825.[2]

It is at this point that Senator Clarke of Arkansas offered an amendment limiting the Government's right to appeal decisions dismissing indictments or arresting judgments for insufficiency of the indictment to instances where the decision was based upon "the validity or construction of the statute." The purpose of that amendment was described by Senator Clarke as follows:

> "Mr. President, the object of the amendment is to limit the right of appeal upon the part of the General Government to the validity or constitutionality of the statute in which the prosecution is proceeding. It has been enlarged by the addition of another

[2] The bill had been amended earlier to require the Government to take an appeal within 30 days. 41 Cong. Rec. 2193–2194.

clause, which gives the right of appeal where the construction by the trial court is such as to decide that there is no offense committed, notwithstanding the validity of the statute, and in other respects the proceeding may remain intact. I think that is a broad enough right to concede to the General Government in the prosecution of persons in the court.

. . . . . .

"In view of the defects that recent years have disclosed, I do not believe it to be sound policy to go beyond the necessities as they have developed defects in our procedure. A case recently occurring has drawn attention to the fact that if a circuit judge or a district judge holding the circuit should determine that a statute of Congress was invalid, the United States is without means of having that matter submitted to a tribunal that under the Constitution has power to settle that question. I do not believe the remedy ought to be any wider than the mischief that has been disclosed. I do not believe that any additional advantages ought to be given to the General Government in the prosecution of persons arraigned in court, but I do believe the paragraph ought to be perfected in that behalf, so as to provide that there shall be an appeal to the court having authority to give uniformity to the practice which shall prevail in all the courts of the United States, and that they shall be ready to say, and say promptly, what the statute means and whether or not it is a valid statute.

. . . . . .

"So I think this amendment gives expression to the proposition that the remedy we provide here now should be no wider than the defect that has been disclosed in the preceding criminal procedure; and that is that whenever the validity of a statute has

been adversely decided by a trial court, wherever its unconstitutionality has been pronounced by a trial court, the Government ought to have the right to promptly submit that to the tribunal having authority to dispose of such questions in order that there may be a uniform enforcement of the law throughout the entire limits of the United States.

"This is the purpose, I have, Mr. President, and having discussed it with the distinguished Senator from Wisconsin . . . and the distinguished Senator from Minnesota [Mr. Nelson], we agreed that that would probably meet the defect." 41 Cong. Rec. 2819–2820. See generally 41 Cong. Rec. 2819–2822.

The bill as thus amended passed the Senate; the House disagreed to the Senate amendment, but yielded in conference. The bill in conference was amended to provide for direct appeals to the Supreme Court. See H. R. Conf. Rep. No. 8113, 59th Cong., 2d Sess. (1970). No explanation was given in the conference report for the exclusive direct appeal route.

I draw from these legislative materials the following relevant propositons: (1) The Congress was definitely advertent to the existence of a governmental appeal right in criminal cases within the District; (2) the Congress explicitly rejected the simple approach of extending the D. C. provision to the Nation; (3) the particular provision of the Act relied on by the Government as supporting its direct appeal in this case was amended with a view to limiting its reach to a relatively precise defect; *i. e.*, the debilitating effect on the enforcement of criminal laws arising from conflicting judicial intepretations; and (4) the substitution of an exclusive direct appeal to this Court, while not expressly explained, is perfectly compatible with the goal of promptly achieving uniformity in construction of statutes applicable nationwide, while at the same time being wholly unnecessary to the resolu-

tion of conflicting district court constructions of local D. C. statutes, given the existence of a right of appeal to the Court of Appeals for the District of Columbia.

II

The question of overlap between the appellate routes available to the Government in criminal cases under the D. C. Code and 18 U. S. C. § 3731 was first dealt with by this Court in *United States* v. *Burroughs*, 289 U. S. 159 (1933). In *Burroughs* the defendants were indicted in the then Supreme Court of the District of Columbia for violation of the Federal Corrupt Practices Act, a statute of nationwide applicability. They successfully demurred on two grounds: one involving the construction of the statute, and the other involving the sufficiency of the indictment as a pleading. The Government took an appeal to the Court of Appeals for the District of Columbia under the D. C. appeals statute. The appellate court certified to this Court the question whether it had jurisdiction over an appeal where a § 3731-type challenge was joined with a challenge to the sufficiency of the indictment as a pleading. The Court disposed of the question by holding that the Criminal Appeals Act is inapplicable to any criminal case appealable under the provision of the D. C. Code:

> *"The Criminal Appeals Act, in naming the courts from which appeals may be taken to this court, employs the phrase 'district courts;' not 'courts of the United States,' or 'courts exercising the same jurisdiction as district courts.' We need not, however, determine whether the statute should be construed to embrace criminal cases tried in the Supreme Court of the District if § 935 of the District Code were not in effect.* That section deals comprehensively with appeals in criminal cases from all

> of the courts of first instance of the District and confers on the Court of Appeals jurisdiction of appeals by the Government seeking review of the judgments of those courts. The Criminal Appeals Act, on the other hand, affects only certain specified classes of decisions in district courts, contains no repealing clause, and no reference to the courts of the District of Columbia or the territorial courts, upon many of which jurisdiction is conferred by language quite similar to that of the Code of Law of the District. We cannot construe it as impliedly repealing the complete appellate system created for the District of Columbia by § 935 of the Code, in the absence of expression on the part of Congress indicating that purpose. Implied repeals are not favored; and if effect can reasonably be given to both statutes, the presumption is that the earlier is intended to remain in force . . . ." 289 U. S., at 163–164.[3]

The holding in *Burroughs* established a complete separation of the two statutory schemes for Government appeals in criminal cases; the essence of the Court's rationale was a presumption against implied repeals.

In 1942, Congress amended the Criminal Appeals Act to provide for Government appeals to the Courts of Appeals from all decisions dismissing indictments or arresting judgments of convictions except where a right of direct appeal to this Court exists. 56 Stat. 271. The

[3] The Court's opinion characterizes *Burroughs* as having "'held only that the term 'district court' in the Criminal Appeals Act did not include the then-existing Supreme Court of the District of Columbia." *Ante*, at [3]. As I read the italicized portion of the above-quoted passage, that is the precise question that the *Burroughs* Court concluded it did *not* have to decide, in light of its holding that the Criminal Appeals Act could not, by implication, effect the repeal of § 935 of the District Code.

new amendment expressly included the United States Court of Appeals for the District of Columbia as one of the intermediate appellate tribunals to which the Government could appeal;[4] in addition, the Act added a new provision to the Judicial Code establishing appellate jurisdiction in the then circuit courts of appeal "in criminal cases on appeals taken by the United States in cases where such appeals are permitted by law." 56 Stat. 272. The latter provision also expressly incorporated the United States Court of Appeals for the District of Columbia.[5] *Ibid.*

The legislative history of the 1942 amendment offers no explication of Congressional intent in including the D. C. courts within the Act.[6] It is certain that this amendment generates some form of overlap between the two statutory schemes for Governmental appeals in criminal cases. In *Carroll* v. *United States*, 354 U. S. 394, 411 (1957), the Court recognized the new situation created by the 1942 amendment:

> "It may be concluded, then, that even today criminal appeals by the Government in the District of Columbia are not limited to the categories set forth in 18 U. S. C. § 3731, although as to cases of the type covered by that special jurisdictional statute, its explicit directions will prevail over the general terms of [the D. C. statute] . . . ."

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[4] These explicit references were subsequently omitted by amendment in 1949, 63 Stat. 97, which altered the language of the statute to conform to the changed nomenclature of the federal courts.

[5] This last provision was an amendment to 28 U. S. C. § 225 (1940 ed.); see 56 Stat. 272 and *Carroll* v. *United States*, *supra*, at n. 5.

[6] The focus was on the decision to accord the Government a right of appeal to the courts of appeal where no direct appeal to this Court lay. See H. R. No. 45, 77th Cong., 1st Sess. (1941); S. Rep. No. 868, 77th Cong., 1st Sess. (1941).

That, however, leaves open the question which cases come within the categories set forth in 18 U. S. C. § 3731.

III

After this Court's holding in *Burroughs*, it was clear that if Congress wished to effectuate any displacement of the pre-1907 route for Government appeals of criminal cases within the District of Columbia, some express manifestation of its intent was required. The 1942 amendment followed the *Burroughs* decision. Since Congress then acted to create some overlap between the two statutes without further limiting the categories of directly appealable criminal cases, it may be argued that we should presume Congress intended, as of 1942, to embrace within the very special appeals procedures of 18 U. S. C. § 3731 criminal cases based upon statutes applicable only within the District.

But that presumption from a completely silent legislative record flies in the face of the principle that statutes creating a right of direct appeal to this Court should be narrowly construed. Cf. *Swift & Co.* v. *Wickham*, 382 U. S. 111, 128–129 (1965); *Florida Lime Growers* v. *Jacobsen*, 362 U. S. 73, 92–93 (Frankfurter, J., dissenting). And, in light of the legislative history of the 1907 Act and this Court's explicit holding in *Burroughs* that the 1907 Act had no impact on cases appealable under the D. C. provision, it is especially inappropriate to rely on the absence of any further limiting language in the 1942 amendment as a justification for reading the term "statute" as encompassing criminal prosecutions in the District based on local as well as nationwide statutes.

The legislative history of the 1907 Act suggests a perfectly plausible reason for interpreting the language "based upon the invalidity or construction of the statute" as excluding D. C. statutes: that language was put in the Act by Senator Clarke with the express intention of

limiting the Act's goal to remedying the precise defect of inconsistent enforcement of criminal statutes arising from the lack of a Government appeal. The Court of Appeals for the District of Columbia constitutes a perfectly adequate appellate tribunal for resolving conflicting interpretations given local statutes by judges within the District of Columbia.[7] Where, however, the Government brings a prosecution in the District of Columbia based on a statute of nationwide applicability, the Court of Appeals for the District of Columbia cannot achieve uniformity in the enforcement of the statute.

As an original proposition, then, a construction of the relevant provisions of the 1907 Act as excluding criminal cases in the District brought under local statutes but including cases brought under nationwide statutes would have been consistent both with the express purpose of Senator Clarke's amendment and the canon of strict construction as applied to direct appeals statutes.[8] But the

[7] The Government suggests a construction of the Criminal Appeals Act excluding D. C. statutes would require the Court to exclude other criminal statutes of only limited territorial application, *e. g.*, 18 U. S. C. §§ 1111–1112; (punishing homicide "[w]ithin the special maritime and territorial jurisdiction of the United States"); 18 U. S. C. §§ 1151–1165 regulating offenses within Indian territory). See Gov. Brief, at 15–16. But I would not construe 18 U. S. C. § 3731 as excluding D. C. criminal cases punishable under D. C. statutes because they are of limited territorial application; rather, the point is that given the existence of a prior right of Government appeal, the risks of disuniformity which Senator Clarke described the statute as intended to cure do not exist.

[8] The Government suggests, in its Supplemental Memorandum for the United States, at 6–7, that a construction of the 1907 Act excluding statutes applicable only within the District of Columbia from the scope of the first two provisions leads to the "anomalous consequence" that 18 U. S. C. § 3731 would still allow a direct appeal in a D. C. case where the motion-in-bar provision is concerned. *E. g., United States* v. *Sweet*, 399 U. S. 517 (1970). The alleged "anomaly" would seem to argue for the conclusion that D. C. cases

Court in *Burroughs* took the position that Congress could not displace the pre-existing appellate route to any extent without indicating an express intent to do so; *Burroughs*, significantly, involved a prosecution under a statute of nationwide applicability. Subsequently, Congress did expressly indicate an intent to displace the alternative appellate route available within the District. The extent of that displacement, I think, should now be measured by the express goal of the relevant provision of the 1907 Act, as limited by Senator Clarke: avoidance of inconsistent enforcement of criminal laws. That theory of legislative purpose—combined with the *Burroughs* holding that Congress should be required to affirmatively indicate an intent to displace the prior appellate route—yields an interpretation of the 1907 Act as amended in 1942 which is consistent with the canon of strict construction generally applied to direct appeals statutes.[9]

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involving the motion-in-bar provision are not directly appealable here, either. Certainly, the Court's disposition in *Sweet* would not foreclose that result.

In any event, the purpose Senator Clarke had in mind in offering his limiting amendment with regard to the first two provisions of 18 U. S. C. § 3731 was rather clearly expressed; that he failed to address himself to the motion-in-bar provision—which, after all, received very little attention in the prolonged debates on the floor of the Senate—hardly justifies an expansive reading of the other provisions of the Act.

[9] The Government relies principally on *Shapiro* v. *Thompson*, 394 U. S. 618, 625 n. 4, as supporting its construction of the generic reference to "statutes" in 18 U. S. C. § 3731 to include statutes applicable only within the District of Columbia. *Shapiro* dealt with 28 U. S. C. § 2282, which requires a three-judge court to hear requests for injunctions against the enforcement of "any Act of Congress" when the ground for the requested relief is the alleged unconstitutionality of the Act. Decisions of such three-judge courts are, under the circumstances set forth in 28 U. S. C. § 1253, directly appealable to this Court. In *Shapiro*, the Court noted at least one prior instance where the Court had taken jurisdiction over

IV

I have little doubt that, had the Criminal Appeals Act not been recently amended to dispense with direct appeals to this Court, see n. 1 *supra*, the interpretation of the Act I have suggested would be adopted by the Court. This Court has never taken jurisdiction over a direct appeal from a dismissal of a prosecution brought in the

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a case involving a statute applicable only within the District and then stated: "Section 2282 requires a three-judge court to hear a challenge to the constitutionality of '*any* Act of Congress.' We see no reason to make an exception for Acts of Congress pertaining to the District of Columbia." 394 U. S., at 625 n. 4 (emphasis in original).

The *Shapiro* approach is obviously inappropriate for the present problem. First, despite the Government's assertion to the contrary, see Gov. Brief, at 15, the phrase "*any* Act of Congress" is arguably broader than a generic reference to "statutes." Indeed, the *Shapiro* Court explicitly chose to emphasize the presence of the word "any" in the relevant portion of that statute. Second, while an exercise of jurisdiction in a case where jurisdiction is not challenged is of little precedential value, the Court in *Shapiro* still chose to take note of such a prior case; in the present context, this Court has never taken jurisdiction of a § 3731 appeal involving a statute applicable only within the District.

Third, and most importantly, Congress at the time of the three-judge court Acts altered the principles of both original and appellate jurisdiction for the substantive categories of litigation involved; the new procedural routes reflect crucial considerations of comity between sovereigns and among the branches of the Federal Government. See generally Currie, The Three-Judge Court in Constitutional Litigation, 32 U. Chi. L. Rev. 1 (1964). There is no legislative history supporting the notion that the new procedures were narrowed to alleviate particular defects of inconsistent constitutional interpretation due to the absence of any appellate route for the substantive categories of cases to be included within the Act.

In these circumstances, it is fair to conclude that the principle of strict construction applicable to such statutes must yield to the "inert language" of the statute. Cf. *Florida Lime Growers* v. *Jacobsen*, 362 U. S. 73, 92 (1960) (Frankfurter, J., dissenting).

District of Columbia for violation of a statute applicable within the District. It is worth noting that, given the Court's adherence to the principles of *Carroll* v. *United States, supra,* the rather absurd waste of our judicial resources on cases such as *United States* v. *Waters,* 175 F. 2d 340, appeal dismissed on motion of the United States, 335 U. S. 869 (1948), and *United States* v. *Sweet,* 399 U. S. 517 (1970), see n. 7 *supra,* could not even be avoided by the exercise of governmental discretion in choosing appellate routes. In light of *Carroll,* I cannot believe that a pefectly acceptable reading of congressional purpose underpinning the definiton of categories of cases directly appealable under 18 U. S. C. § 3731 which excludes statutes applicable only within the District of Columbia would have been turned down by the Court.

Of course, the recent elimination of the direct appeal route removes a great deal of the incentive to continue the stringent standards of construction with respect to this statute that have traditionally prevailed in this Court. Indeed, at this stage of the game, the canon of strict construction produces the ironic result of compelling a relatively greater expenditure of judicial energies in assessing our jurisdiction over the remainder of the criminal cases pending in the district courts of the Nation at the time of the most recent amendment than would be involved in deciding those cases on the merits. Nonetheless, this very Term we have indicated that we intend to adhere to the rules of construction evolved by this Court during the long and tortuous history of this statute. *United States* v. *Weller,* No. 77, October Term 1970 (decided February 24, 1971).

The only response we are offered to the reading of congressional purpose I have suggested is that the interests of avoiding inconsistent enforcement of criminal laws argues for exercising jurisdiction over this case because similar statutes in other jurisdictions are under attack

on vagueness grounds. See the Court's opinion, at [3]. Surely those of my Brethren who subscribe to the views on jurisdiction expressed in the opinion of the Court must recognize that we cannot limit the category of appealable cases under this provision of the Act to prosecutions brought under D. C. statutes which are (a) duplicated in other jurisdictions, and (b) under attack on similar federal question grounds in other jurisdictions. The proffered response is, therefore, not truly a reason for concluding we have jurisdiction over the relevant category of cases; rather, it is a reason for exercising our power in this one case to settle Dr. Vuitch's vagueness claim in spite of the absence of the jurisdictional prerequisites which legitimize the exercise of that judicial power.

V

Having concluded that the Government cannot directly appeal the dismissal of the indictment to this Court under the provisions of 18 U. S. C. § 3731, it also follows that we cannot utilize the remand provisions of that statute to reroute the appeal to the Court of Appeals for the District of Columbia. However, we do have jurisdiction to determine our jurisdiction, and, in the analogous three-judge court situation where an alternative appellate route exists but the statute according this Court direct jurisdiction over the certain appeals includes no remand procedure, this Court has vacated the judgment of the court of original jurisdiction and remanded the case to that court for the entry of a fresh decree from which timely appeal may be taken to the proper appellate tribunal. *Rockefeller* v. *Catholic Medical Center of Brooklyn & Queens*, 397 U. S. 820 (1970). The instant case, of course, is a criminal prosecution, and there is a consideration not present in the three-judge court situation: *i. e.*, the additonal anxiety caused the

defendant by virtue of the Government's erroneous choice of appellate routes. But, while 18 U. S. C. § 3731 cannot empower us to transfer the case, that statute is still relevant as an expression of congressional policy to save the Government's appeal where an erroneous choice of appellate routes is made, even at the expense of additional anxiety to the defendant. Accordingly, I think the proper disposition of this case would be to vacate the judgment of the District Court and remand the case for the entry of a fresh judgment from which the Government could take a timely appeal to the Court of Appeals for the District of Columbia pursuant to 23 D. C. Code § 105.

VI

Notwithstanding the views on jurisdiction expressed above, and speaking only for myself, and not for those of my Brethren who agree with my discussion of the jurisdictional issue in this case, I have concluded, substantially for the reasons set forth in MR. JUSTICE BLACKMUN's separate opinion, that I should also reach the merits. Accordingly, I concur in Part II of the Court's opinion and the judgment of the Court.

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch.	On Appeal From the United States District Court for the District of Columbia.

[April 21, 1971]

Mr. Justice Stewart, dissenting in part.

I agree that we have jurisdiction of this appeal for the reasons stated in Part I of the Court's opinion.

As to the merits of this controversy, I share at least some of the constitutional doubts about the abortion statute expressed by the District Court. But, as this Court today correctly points out, "statutes should be construed whenever possible so as to uphold their constitutionality." The statute before us can be so construed, I think, simply by extending the reasoning of the Court's opinion to its logical conclusion.

The statute legalizes any abortion performed "under the direction of a competent licensed practitioner of medicine" if "necessary for the preservation of the mother's life or health." Under the statute, therefore, the legal practice of medicine in the District of Columbia includes the performing of abortions. For the practice of medicine consists of doing those things which, in the judgment of a physician, are necessary to preserve a patient's life or health. As the Court says, "whether a particular operation is necessary for a patient's physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered."

It follows, I think, that when a physician has exercised his judgment in favor of performing an abortion, he has, by hypothesis, not violated the statute. To put it an-

other way, I think the question of whether the performance of an abortion is "necessary for the mother's life or health" is entrusted under the statute exclusively to those licensed to practice medicine, without the overhanging risk of incurring criminal liability at the hands of a second-guessing lay jury. I would hold, therefore, that "a competent licensed practitioner of medicine" is wholly immune from being charged with the commission of a criminal offense under this law.

It is true that the statute can be construed in other ways, as MR. JUSTICE DOUGLAS has made clear. But I would give it the reading I have indicated "in the candid service of avoiding a serious constitutional doubt." *United States* v. *Rumely*, 345 U. S. 41, 47.

SUPREME COURT OF THE UNITED STATES

No. 84.—October Term, 1970

United States, Appellant, v. Milan Vuitch.	On Appeal From the United States District Court for the District of Columbia.

[April 21, 1971]

Mr. Justice Blackmun.

Although I join Mr. Justice Harlan in his conclusion that this case is not properly here by direct appeal under 18 U. S. C. § 3731, a majority, and thus the Court, holds otherwise. The case is therefore here and requires decision.

The five Justices constituting the majority, however, are divided on the merits. One feels that 22 D. C. Code § 201 lacks the requirements of procedural due process and would affirm the dismissal of the indictment. One would hold that a licensed physician is immune from charge under the statute. Three would hold that, properly construed, the statute is not unconstitutionally vague and that the dismissal of the indictment on that ground was error.

Because of the inability of the jurisdictional-issue majority to agree upon the disposition of the case, I feel obligated not to remain silent as to the merits. See *Screws* v. *United States*, 325 U. S. 91, 134 (1945) (addendum by Mr. Justice Rutledge); *United States* v. *Jorn*, 400 U. S. 470, 487–488 (1971) (statement of Black and Brennan, JJ.); *Mills* v. *Alabama*, 384 U. S. 214, 222–223 (1966) (separate opinion of Harlan, J.); *Kesler* v. *Department of Public Safety*, 369 U. S. 153, 174, 179 (concurring opinion of Stewart, J., and dissenting opinion of Warren, C. J.). Assuming, as I must in the light of the Court's decision, that the Court does have jurisdiction of the appeal, I join Part II of Mr. Justice Black's opinion and the judgment of the Court.

Item No. 14

juris. postponed to hearing on merits, 401 U.S ___(May 3, 1971) (No. 808, 1970 Term; renumbered No. 70-18, 1971 Term)

Jane ROE, Plaintiff,

v.

Henry WADE, Defendant,

v.

James Hubert HALLFORD, M.D., Intervenor.

John DOE and Mary Doe, Plaintiffs,

v.

Henry WADE, Defendant.

Civ. A. Nos. 3-3690-B, 3-3691-C.

United States District Court,
N. D. Texas,
Dallas Division.
June 17, 1970.

Action for judgment declaring Texas abortion laws unconstitutional and to enjoin their enforcement. The three-judge District Court held that laws prohibiting abortions except for purpose of saving life of the mother violated right secured by the Ninth Amendment to choose whether to have children and were unconstitutionally overbroad and vague, but Court would abstain from issuing injunction against enforcement of the laws.

Order accordingly.

1. Constitutional Law ⇐42

Physician challenging constitutionality of Texas abortion laws had standing to raise rights of his patients, single women and married couples, as well as rights of his own. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196.

2. Constitutional Law ⇐42

Logical nexus existed between status asserted by plaintiffs, a married couple, single woman and practicing physician challenging constitutionality of Texas abortion laws, and claim sought to be adjudicated, and plaintiffs had standing. Vernon's Ann.Tex.P.C. art. 1196; 28 U.S.C.A. § 2201.

3. Courts ⇐300

Contentiousness between pregnant woman, physician and district attorney of Dallas County was sufficient to establish a "case of actual controversy" with respect to constitutionality of Texas abortion laws. 28 U.S.C.A. § 2201.

See publication Words and Phrases for other judicial constructions and definitions.

4. Courts ⇐280.4

In absence of possibility that adjudication in state courts would eliminate necessity for federal district court to pass upon plaintiffs' Ninth Amendment claim respecting constitutionality of Texas abortion laws or physician's attack on laws for vagueness, abstention as to plaintiffs' request for declaratory judgment was unwarranted. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196; U.S.C.A.Const. Amend. 9.

5. Abortion ⇐1

Texas laws prohibiting abortions except for purpose of saving life of mother deprived single women and married couples of their right, secured by the Ninth Amendment, to choose whether to have children. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196; U.S.C.A.Const. Amend. 9.

6. Constitutional Law ⇐48

District attorney had burden to demonstrate that infringement by state abortion laws upon plaintiffs' fundamental right to chose whether to have children was necessary to support compelling state interest. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196.

7. Constitutional Law ⇐38

Fact that statutory scheme serves permissible or even compelling state interests will not save it from consequences of unconstitutional overbreadth.

8. Abortion ⇐1

While Ninth Amendment right to choose to have abortion is not unqualified or unfettered, statute designed to regulate circumstances of abortions must restrict its scope to compelling state interests. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196; U.S.C.A.Const. Amend. 9.

9. Abortion ⇐1

Texas laws prohibiting abortions except for purpose of saving life of mother are unconstitutionally overbroad in failing to limit scope to compelling state interests. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196; U.S.C.A.Const. Amend. 9.

10. Criminal Law ⇐13

Texas laws prohibiting abortions except for purpose of saving life of mother are unconstitutionally vague in failing to provide physicians with proper notice of what acts in their daily practice and consultation will subject them to criminal liability. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196.

11. Courts ⇐508(7)

Federal policy of noninterference with state criminal prosecutions must be followed except in cases where statutes are justifiably attacked on their face as abridging free expression, or where statutes are justifiably attacked as applied for the purpose of discouraging protected activities. U.S.C.A.Const. Amends. 1, 9.

12. Courts ⇐508(7)

Texas abortion laws, although unconstitutional in depriving single women and married couples of right secured by Ninth Amendment to choose whether to have children and as being vague and overbroad, could not be justifiably at-

tacked on their face as abridging free expression or as being applied for purpose of discouraging protected activities, and federal court would abstain from enjoining enforcement of the laws. Vernon's Ann.Tex.P.C. arts. 1191–1194, 1196; U.S. C.A.Const. Amends. 1, 9.

Linda N. Coffee, Dallas, Tex., Sarah Weddington, Austin, Tex., for plaintiffs.

Fred Bruner, Daugherty, Bruner, Lastelick & Anderson, Ray L. Merrill, Jr., Dallas, Tex., for intervenor.

John B. Tolle, Asst. Dist. Atty., Dallas, Tex., Jay Floyd, Asst. Atty. Gen., Austin, Tex., for defendant.

Before GOLDBERG, Circuit Judge, and HUGHES and TAYLOR, District Judges.

1. On March 3, 1970, plaintiff Jane Roe filed her original complaint in CA-3-3690-B under the First, Fourth, Fifth, Eighth, Ninth, and Fourteenth Amendments to the United States Constitution. She alleged jurisdiction to be conferred upon the Court by Title 28, United States Code, Sections 1331, 1343, 2201, 2202, 2281, and 2284 and by Title 42, United States Code, Section 1983. On April 22, plaintiff Roe amended her complaint to sue "on behalf of herself and all others similarly situated."

On March 23, James Hubert Hallford, M. D., was given leave to intervene. Hallford's complaint recited the same constitutional and jurisdictional grounds as the complaint of plaintiff Roe. According to his petition for intervention, Hallford seeks to represent "himself and the class of people who are physicians, licensed to practice medicine under the laws of the State of Texas and who fear future prosecution."

On March 3, 1970, plaintiffs John and Mary Doe filed their original complaint in CA-3-3691-C. The complaint of plaintiffs Doe recited the same constitutional and jurisdictional grounds as had the complaint of plaintiff Roe in CA-3-3690 and, like Roe, plaintiffs Doe subsequently amended their complaint so as to assert a class action.

Plaintiffs Roe and Doe have adopted pseudonyms for purposes of anonymity.

PER CURIAM:

Two similar cases are presently before the Court on motions for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. The defendant in both cases is Henry Wade, District Attorney of Dallas County, Texas. In one action plaintiffs are John and Mary Doe, and in the other Jane Roe and James Hubert Hallford, M.D., intervenor.[1]

[1] From their respective positions of married couple, single woman, and practicing physician, plaintiffs attack Articles 1191, 1192, 1193, 1194, and 1196 of the Texas Penal Code,[2] hereinafter referred to as the Texas Abortion Laws. Plaintiffs allege that the Texas Abortion Laws deprive married couples and single women of the right to choose whether to have children, a right secured by the Ninth Amendment.

2. *Article 1191 Abortion*

If any person shall designedly administer to a pregnant woman or knowingly procure to be administered with her consent any drug or medicine, or shall use towards her any violence or means whatever externally or internally applied, and thereby procure an abortion, he shall be confined in the penitentiary not less than two nor more than five years; if it be done without her consent, the punishment shall be doubled. By "abortion" is meant that the life of the fetus or embryo shall be destroyed in the woman's womb or that a premature birth thereof be caused.

Article 1192 Furnishing the Means

Whoever furnishes the means for procuring an abortion knowing the purpose intended is guilty as an accomplice.

Article 1193 Attempt at Abortion

If the means used shall fail to produce an abortion, the offender is nevertheless guilty of an attempt to produce abortion, provided it be shown that such means were calculated to produce that result, and shall be fined not less than one hundred nor more than one thousand dollars.

Article 1194 Murder in Producing Abortion

If the death of the mother is occasioned by an abortion so produced or by an attempt to effect the same it is murder.

Article 1196 By Medical Advice

Nothing in this chapter applies to an abortion procured or attempted by medical advice for the purpose of saving the life of the mother.

Defendant challenges the standing of each of the plaintiffs to bring this action. However, it appears to the Court that Plaintiff Roe and plaintiff-intervenor Hallford occupy positions *vis-a-vis* the Texas Abortion Laws sufficient to differentiate them from the general public. Compare Pierce v. Society of Sisters, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925), and Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965),[3] with Frothingham v. Mellon, 262 U.S. 447, 43 S.Ct. 597, 67 L. Ed. 1078 (1923). Plaintiff Roe filed her portion of the suit as a pregnant woman wishing to exercise the asserted constitutional right to choose whether to bear the child she was carrying. Intervenor Hallford alleged in his portion of the suit that, in the course of daily exercise of his duty as a physician and in order to give his patients access to what he asserts to be their constitutional right to choose whether to have children, he must act so as to render criminal liability for himself under the Texas Abortion Laws a likelihood. Dr. Hallford further alleges that Article 1196 of the Texas Abortion Laws is so vague as to deprive him of warning of what produces criminal liability in that portion of his medical practice and consultations involving abortions.

[2] On the basis of plaintiffs' substantive contentions,[4] it appears that there then exists a "nexus between the status asserted by the litigant[s] and the claim[s] [they present]." Flast v. Cohen, 392 U.S. 83, 102, 88 S.Ct. 1942, 20 L.Ed.2d 947 (1968).

[3] Further, we are satisfied that there presently exists a degree of contentiousness between Roe and Hallford and the defendant to establish a "case of actual controversy" as required by Title 28, United States Code, Section 2201. Golden v. Zwickler, 394 U.S. 103, 89 S.Ct. 956, 22 L.Ed.2d 113 (1969).

Each plaintiff seeks as relief, *first*, a judgment declaring the Texas Abortion Laws unconstitutional on their face and, *second*, an injunction against their enforcement. The nature of the relief requested suggests the order in which the issues presented should be passed upon.[5] Accordingly, we see the issues presented as follows:

I. Are plaintiffs entitled to a declaratory judgment that the Texas Abortion Laws are unconstitutional on their face?

II. Are plaintiffs entitled to an injunction against the enforcement of these laws?

I.

Defendants have suggested that this Court should abstain from rendering a decision on plaintiffs' request for a declaratory judgment. However, we are guided to an opposite conclusion by the authority of Zwickler v. Koota, 389 U.S. 241, 248–249, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967):

> "The judge-made doctrine of abstention * * * sanctions * * * escape only in narrowly limited 'special circumstances.' * * * One of the 'special circumstances' * * * is the susceptibility of a state statute of a construction by the state courts that would avoid or modify the constitutional question."

The Court in Zwickler v. Koota subsequently quoted from United States v. Livingston, 179 F.Supp. 9, 12–13 (E.D. S.C.1959):

> "Regard for the interest and sovereignty of the state and reluctance

3. By the authority of *Griswold*, Dr. Hallford has standing to raise the rights of his patients, single women and married couples, as well as rights of his own.

4. "[I]n ruling on standing, it is both appropriate and necessary to look to the substantive issues * * * to determine whether there is a logical nexus between the status asserted and the claim sought to be adjudicated." Flast v. Cohen, 392 U.S. 83, 102, 88 S.Ct. 1942, 20 L.Ed.2d 947 (1968).

5. Zwickler v. Koota, 389 U.S. 241, 254, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967); Cameron v. Johnson, 390 U.S. 611, 615, 88 S.Ct. 1335, 20 L.Ed.2d 182 (1968).

needlessly to adjudicate constitutional issues may require a federal District Court to abstain from adjudication if the parties may avail themselves of an appropriate procedure to obtain state interpretation of state laws requiring construction. * * * The decision in [Harrison v. N.A.A.C.P., 360 U.S. 167, 79 S.Ct. 1025, 3 L.Ed.2d 1152], however, is not a broad encyclical commanding automatic remission to the state courts of all federal constitutional questions arising in the application of state statutes. * * * Though never interpreted by a state court, if a state statute is not fairly subject to an interpretation which will avoid or modify the federal constitutional question, it is the duty of a federal court to decide the federal question when presented to it. Any other course would impose expense and long delay upon the litigants without hope of its bearing fruit."[6]

[4] Inasmuch as there is no possibility that state question adjudication in the courts of Texas would eliminate the necessity for this Court to pass upon plaintiffs' Ninth Amendment claim or Dr. Hallford's attack on Article 1196 for vagueness, abstention as to their request for declaratory judgment is unwarranted. Compare City of Chicago v. Atchison, T. & S. F. R. Co., 357 U.S. 77, 84, 78 S.Ct. 1063, 2 L.Ed.2d 1174 (1958), with Reetz v. Bozanich, 397 U.S. 82, 90 S.Ct. 788, 25 L.Ed.2d 68 (1970).

[5] On the merits, plaintiffs argue as their principal contention[7] that the Texas Abortion Laws must be declared unconstitutional because they deprive single women and married couples of their right, secured by the Ninth Amendment,[8] to choose whether to have children. We agree.

The essence of the interest sought to be protected here is the right of choice over events which, by their character and consequences, bear in a fundamental manner on the privacy of individuals. The manner by which such interests are secured by the Ninth Amendment is illustrated by the concurring opinion of Mr. Justice Goldberg in Griswold v. Connecticut, 381 U.S. 479, 492, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965):

"[T]he Ninth Amendment shows a belief of the Constitution's authors that *fundamental* rights exist that are not expressly enumerated in the first eight amendments and intent that the list of rights included there not be deemed exhaustive." * * *

"The Ninth Amendment simply shows the intent of the Constitution's authors that other *fundamental* personal rights should not be denied such protection or disparaged in any other way simply because they are not specifically listed in the first eight constitutional amendments." (Emphasis added.)[9]

Relative sanctuaries for such "fundamental" interests have been established

6. 389 U.S. at 250–251, 88 S.Ct. at 396–397. (Citations omitted.)

7. Aside from their Ninth Amendment and vagueness arguments, plaintiffs have presented an array of constitutional arguments. However, as plaintiffs conceded in oral argument, these additional arguments are peripheral to the main issues. Consequently, they will not be passed upon.

8. "The enumeration in the Constitution, of certain rights shall not be construed to deny or disparage others retained by the people."

9. At 492, 85 S.Ct. at 1686 the opinion states: "In determining which rights are fundamental, judges are not left at large to decide cases in light of their personal and private notions. Rather, they must look to the 'traditions and [collective] conscience of our people' to determine whether a principle is 'so rooted [there] * * * as to be ranked as fundamental'. Snyder v. [Commonwealth of] Massachusetts, 291 U.S. 97, 105 [54 S.Ct. 330, 78 L.Ed. 674]. The inquiry is whether a right involved 'is of such a character that it cannot be denied without violating those "fundamental principles of liberty and justice which lie at the base of all our civil and political institutions." * * *' Powell v. Alabama, 287 U.S. 45, 67 [53 S.Ct. 55, 77 L.Ed. 158]."

for the family,[10] the marital couple,[11] and the individual.[12]

Freedom to choose in the matter of abortions has been accorded the status of a "fundamental" right in every case coming to the attention of this Court where the question has been raised. Babbitz v. McCann, 312 F.Supp. 725 (E.D. Wis.1970); People v. Belous, 80 Cal. Rptr. 354, 458 P.2d 194 (Cal.1969); State v. Munson, (South Dakota Circuit Court, Pennington County, April 6, 1970). *Accord*, United States v. Vuitch, 305 F.Supp. 1032 (D.D.C.1969). The California Supreme Court in *Belous* stated:

> "The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a 'right of privacy' or 'liberty' in matters related to marriage, family, and sex." 80 Cal.Rptr. at 359, 458 P.2d at 199.

The District Court in *Vuitch* wrote:

> "There has been * * * an increasing indication in the decisions of the Supreme Court of the United States that as a secular matter a woman's liberty and right of privacy extends to family, marriage and sex matters and may well include the right to remove an unwanted child at least in early stages of pregnancy." 305 F.Supp. at 1035.

Writing about Griswold v. Connecticut, *supra*, and the decisions leading up to it, former Associate Justice Tom C. Clark observed:

> "The result of these decisions is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution." [13]

[6] Since the Texas Abortion Laws infringe upon plaintiffs' fundamental right to choose whether to have children, the burden is on the defendant to demonstrate to the satisfaction of the Court that such infringement is necessary to support a compelling state interest.[14] The defendant has failed to meet this burden.

10. Pierce v. Society of Sisters, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925); Meyer v. Nebraska, 262 U.S. 390, 43 S.Ct. 625, 67 L.Ed. 1042 (1923); and Prince v. Commonwealth of Massachusetts, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645 (1944).

11. Loving v. Commonwealth of Virginia, 388 U.S. 1, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967); Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); and Buchanan v. Batchelor, 308 F.Supp. 729 (N.D.Tex.1970).

12. Skinner v. Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942); and Stanley v. Georgia, 394 U.S. 557, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969).

13. Religion, Morality, and Abortion: A Constitutional Appraisal, 2 Loyola Univ. L.Rev. 1, 8 (1969). Mr. Justice Clark goes on to write, "* * * abortion falls within that sensitive area of privacy—the marital relation. One of the basic values of this privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was to prevent formation of the fetus. This, the Court found, was constitutionally protected. If an individual may prevent contraception, why can he not nullify that conception when prevention has failed?" *Id.* at 9.

14. "In a long series of cases this Court has held that where fundamental personal liberties are involved, they may not be abridged by the States simply on a showing that a regulatory statute has some rational relationship to the effectuation of a proper state purpose. 'Where there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling.' Bates v. [City of] Little Rock, 361 U.S. 516, 524 [80 S.Ct. 412, 4 L.Ed.2d 480]." Griswold v. Connecticut, 381 U.S. 479, 497, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) (concurring opinion of Mr. Justice Goldberg). *See also* Kramer v. Union Free School District, 395 U.S. 621, 89 S.Ct. 1886, 23 L.Ed.2d 583 (1969).

To be sure, the defendant has presented the Court with several compelling justifications for state presence in the area of abortions. These include the legitimate interests of the state in seeing to it that abortions are performed by competent persons and in adequate surroundings. Concern over abortion of the "quickened" fetus may well rank as another such interest. The difficulty with the Texas Abortion Laws is that, even if they promote these interests,[15] they far outstrip these justifications in their impact by prohibiting *all* abortions except those performed "for the purpose of saving the life of the mother." [16]

[7–9] It is axiomatic that the fact that a statutory scheme serves permissible or even compelling state interests will not save it from the consequences of unconstitutional overbreadth. *E. g.*, Thornhill v. Alabama, 310 U.S. 88, 60 S.Ct. 736, 84 L.Ed. 1093 (1940); Buchanan v. Batchelor, 308 F.Supp. 729 (N.D.Tex. 1970). While the Ninth Amendment right to choose to have an abortion is not unqualified or unfettered, a statute designed to regulate the circumstances of abortions must restrict its scope to compelling state interests. There is unconstitutional overbreadth in the Texas Abortion Laws because the Texas Legislature did not limit the scope of the statutes to such interests. On the contrary, the Texas statutes, in their monolithic interdiction, sweep far beyond any areas of compelling state interest.

[10] Not only are the Texas Abortion Laws unconstitutionally overbroad, they are also unconstitutionally vague. The Supreme Court has declared that "a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process of law." Connally v. General Construction Co., 269 U.S. 385, 391, 46 S.Ct. 126, 70 L.Ed. 322 (1926). "No one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the State commands or forbids." Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 83 L.Ed. 888 (1939). *See also* Giaccio v. Pennsylvania, 382 U.S. 399, 402–403, 86 S.Ct. 518, 15 L.Ed.2d 447 (1966). Under this standard the Texas statutes fail the vagueness test.

The Texas Abortion Laws fail to provide Dr. Hallford and physicians of his class with proper notice of what acts in their daily practice and consultation will subject them to criminal liability. Article 1196 provides:

> "Nothing in this chapter applies to an abortion procured or attempted by medical advice for the purpose of saving the life of the mother."

It is apparent that there are grave and manifold uncertainties in the application of Article 1196. How *likely* must death be? Must death be certain if the abortion is not performed? Is it enough that the woman could not undergo birth without an ascertainably higher possibility of death than would normally be the case? What if the woman threatened suicide if the abortion was not performed? How *imminent* must death be if the abortion is not performed? Is it sufficient if having the child will shorten the life of the woman by a number of years? These questions simply cannot be answered.

The grave uncertainties in the application of Article 1196 and the consequent uncertainty concerning criminal liability under the related abortion statutes are more than sufficient to render the Texas Abortion Laws unconstitutionally vague in violation of the Due Process Clause of the Fourteenth Amendment.

15. It is not clear whether the Texas laws presently serve the interests asserted by the defendant. For instance, the Court gathers from a reading of the challenged statutes that they presently would permit an abortion "for the purpose of saving the life of the mother" to be performed *anywhere* and quite possibly by *one other than a physician*.

16. Article 1196.

II.

We come finally to a consideration of the appropriateness of plaintiffs' request for injunctive relief. Plaintiffs have suggested in oral argument that, should the Court declare the Texas Abortion Laws unconstitutional, that decision would of itself warrant the issuance of an injunction against state enforcement of the statutes. However, the Court is of the opinion that it must abstain from granting the injunction.

Clearly, the question whether to abstain concerning an injunction against the enforcement of state criminal laws is divorced from concerns of abstention in rendering a declaratory judgment. Quoting from Zwickler v. Koota,

> "[A] request for a declaratory judgment that a state statute is overbroad on its face must be considered independently of any request for injunctive relief against enforcement of that statute. We hold that a federal district court has the duty to decide the appropriateness and merits of the declaratory request irrespective of its conclusion as to the propriety of the issuance of the injunction." 389 U.S. at 254, 88 S.Ct. at 399.

[11] The strong reluctance of federal courts to interfere with the process of state criminal procedure was reflected in Dombrowski v. Pfister, 380 U.S. 479, 484–485, 85 SCt. 1116, 1120–21, 14 L.Ed. 2d 22 (1965):

> "[T]he Court has recognized that federal interference with a State's good-faith administration of its criminal laws is peculiarly inconsistent with our federal framework. It is generally to be assumed that state courts and prosecutors will observe constitutional limitations as expounded by this Court, and that the mere possibility of erroneous initial application of constitutional standards will usually not amount to the irreparable injury necessary to justify a disruption of orderly state proceedings."

This federal policy of non-interference with state criminal prosecutions must be followed except in cases where "statutes are justifiably attacked on their face as abridging free expression," or where statutes are justifiably attacked "as applied for the purpose of discouraging protected activities." Dombrowski v. Pfister, 380 U.S. at 489–490, 85 S.Ct. at 1122.

[12] Neither of the above prerequisites can be found here. While plaintiffs' first substantive argument rests on notions of privacy which are to a degree common to the First and Ninth Amendments, we do not believe that plaintiffs can seriously argue that the Texas Abortion Laws are vulnerable "on their face as abridging free expression." [17] Further, deliberate application of the statutes "for the purpose of discouraging protected activities" has not been alleged. We therefore conclude that we must abstrain from issuing an injunction against enforcement of the Texas Abortion Laws.

CONCLUSION

In the absence of any contested issues of fact, we hold that the motions for summary judgment of the plaintiff Roe and plaintiff-intervenor Hallford should be granted as to their request for declaratory judgment. In granting declaratory relief, we find the Texas Abortion Laws unconstitutional for vagueness and overbreadth, though for the reasons herein stated we decline to issue an injunction. We need not here delineate the factors which could qualify the right of a mother to have an abortion. It is sufficient to state that legislation concerning abortion must address itself to more than a bare negation of that right.

17. "[T]he door is not open to all who would test the validity of state statutes or conduct a federally supervised pre-trial of a state prosecution by the simple expedient of alleging that the prosecution somehow affects First Amendment rights." Porter v. Kimzey, 309 F.Supp. 993, 995 (N.D.Ga.1970).

JUDGMENT

This action came on for hearing on motions for summary judgment before a three-judge court composed of Irving L. Goldberg, Circuit Judge, Sarah T. Hughes and W. M. Taylor, Jr., District Judges. The defendant in both cases is Henry Wade, District Attorney of Dallas County, Texas. In one action plaintiffs are John and Mary Doe, husband and wife, and in the other Jane Roe and James Hubert Hallford, M.D., intervenor.

The case having been heard on the merits, the Court, upon consideration of affidavits, briefs and arguments of counsel, finds as follows:

Findings of Fact

(1) Plaintiff Jane Roe, plaintiff-intervenor James Hubert Hallford, M.D., and the members of their respective classes have standing to bring this lawsuit.

(2) Plaintiffs John and Mary Doe failed to allege facts sufficient to create a present controversy and therefore do not have standing.

(3) Articles 1191, 1192, 1193, 1194 and 1196 of the Texas Penal Code, hereinafter referred to as the Texas Abortion Laws, are so written as to deprive single women and married persons of the opportunity to choose whether to have children.

(4) The Texas Abortion Laws are so vaguely worded as to produce grave and manifold uncertainties concerning the circumstances which would produce criminal liability.

Conclusions of Law

(1) This case is a proper one for a three-judge court.

(2) Abstention, concerning plaintiffs' request for a declaratory judgment, is unwarranted.

(3) The fundamental right of single women and married persons to choose whether to have children is protected by the Ninth Amendment, through the Fourteenth Amendment.

(4) The Texas Abortion Laws infringe upon this right.

(5) The defendant has not demonstrated that the infringement of plaintiffs' Ninth Amendment rights by the Texas Abortion Laws is necessary to support a compelling state interest.

(6) The Texas Abortion Laws are consequently void on their face because they are unconstitutionally overbroad.

(7) The Texas Abortion Laws are void on their face because they are vague in violation of the Due Process Clause of the Fourteenth Amendment.

(8) Abstention, concerning plaintiffs' request for an injunction against the enforcement of the Texas Abortion Laws, is warranted.

It is therefore ordered, adjudged and decreed that: (1) the complaint of John and Mary Doe be dismissed; (2) the Texas Abortion Laws are declared void on their face for unconstitutional overbreadth and for vagueness; (3) plaintiffs' application for injunction be dismissed.

WEST KEY NUMBER SYSTEM

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juris. postponed to hearing on merits, 401 U.S. ___(May 3, 1971) (No. 971, 1970 Term; renumbered No. 70-40, 1971 Term)



Mary DOE et al.,

v.

Arthur K. BOLTON, as Attorney General of the State of Georgia, Lewis R. Slaton as District Attorney of Fulton County, Georgia and Herbert T. Jenkins, as Chief of Police of the City of Atlanta.

Civ. A. No. 13676.

United States District Court,
N. D. Georgia,
Atlanta Division.
July 31, 1970.
Supplemental Opinion Oct. 14, 1970.

Class action attacking validity of state abortion statute. A Three-Judge District Court held that claims by physicians and nurses that because of state abortion statute they were not free to perform or counsel obtaining of abor-

tions and were therefore unconstitutionally restricted in practice of their professions did not present justiciable controversy and that statute was invalid to extent it limited cases in which abortion could be performed.

Order accordingly.

1. Federal Civil Procedure ⇐9

State Attorney General who was required to represent state in legal proceedings or to give opinion on abortion statute when requested by Governor and who was head of department which was vested with jurisdiction in all matters of law relating to governmental departments, boards and agencies was proper defendant in class action attacking state abortion statute. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983; Code Ga. §§ 26–1201 et seq., 40–1602, 40–1614; Const.Ga. art. 6, § 10, par. 2.

2. Declaratory Judgment ⇐292

Physicians, nurses, ministers and social workers who claimed that because of state statute they were not free to perform or counsel obtaining of abortions and were therefore unconstitutionally restricted in practice of their professions had standing to bring action seeking declaratory judgment as to validity and injunction against enforcement of statute. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983; Code Ga. § 26–1201 et seq.

3. Declaratory Judgment ⇐274

For federal courts to have jurisdiction in declaratory judgment proceeding attacking validity of state statute, there must be actual controversy in which constitutionality of statute is drawn into question in truly adversary context. U.S.C.A.Const. art. 3, § 2.

4. Declaratory Judgment ⇐121

Where plaintiff's request for therapeutic abortion had been denied by hospital committee on ground that her situation did not come within terms of state abortion statute, there was actual interference with claimed constitutional right by decision of body which state had vested with power to grant or deny legal abortions and plaintiff's declaratory judgment action attacking statute presented justiciable controversy. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983; Code Ga. §§ 26–1201, 26–1202, 26–1202(a) (1–3), (b).

5. Declaratory Judgment ⇐123

Claims by physicians and nurses that because of state abortion statute they were not free to perform or counsel obtaining of abortions and were therefore unconstitutionally restricted in practice of their professions did not present justiciable controversy. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983; Code Ga. §§ 26–1201, 26–1202, 26–1202(a) (1–3), (b).

6. Courts ⇐489(1)

There is no requirement that litigant in federal court exhaust state judicial remedies, where he is asserting claim in proceeding other than habeas corpus involving subject over which federal and state courts have concurrent jurisdiction.

7. Abortion ⇐1

State may not unduly limit reasons for which woman may obtain abortion but may legitimately require that decision to terminate her pregnancy be one reached only on consideration of more factors than desires of woman and her ability to find willing physician. U.S.C.A.Const. Amends. 9, 14; Code Ga. § 26–1201 et seq.

8. Constitutional Law ⇐82

Concept of personal liberty embodies right to privacy which apparently is also broad enough to include decision to abort pregnancy. U.S.C.A.Const. Amend. 9.

9. Abortion ⇐1

Once embryo has formed, decision to abort its development cannot be considered purely private one affecting only man and woman and state may assert legitimate area of control short of invasion of personal right of initial decision. U.S.C.A.Const. Amends. 9, 14; Code Ga. § 26–1201 et seq.

10. Constitutional Law ⇐250

Mere fact that physicians and psychiatrists are more accessible to rich people than to poor people, making abortions more available to wealthy than to indigent, is not in itself a violation of equal protection. U.S.C.A.Const. Amend. 14; Code Ga. § 26–1201 et seq.

11. Abortion ⇐1

Reasons for abortion may not be prescribed but quality of decision as well as manner of its execution are properly within realm of state control. U.S.C.A. Const. Amends. 9, 14; Code Ga. § 26–1201 et seq.

12. Abortion ⇐1

Declaratory Judgment ⇐22

State abortion statute to extent it limited cases in which physician could legally perform abortion to cases where continuation of pregnancy would endanger life of woman, fetus would very likely be born with irremediable mental or physical defect or pregnancy resulted from forcible or statutory rape in which case woman must give written statement under oath as to time and place of rape and name of rapist, if known with copy of statement going to law enforcement officials and to extent it provided for declaratory judgment action as to validity of abortion to be performed was unconstitutional. U.S.C.A.Const. Amends. 9, 14; Code Ga. § 26–1202(a) (1–3), (b) (3, 6), (c).

13. Courts ⇐508(7)

Although federal court found that state abortion statute was unconstitutional in certain respects, injunction against state prosecutions which had not been instituted would be denied. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983; Code Ga. § 26–1201 et seq.

Supplemental Opinion

14. Federal Civil Procedure ⇐331

Where hospital which had previously denied application for abortion reconsidered and granted application, motion by party seeking abortion to intervene in class action attacking state abortion statute would be denied.

15. Federal Civil Procedure ⇐331

In absence of showing that pregnant woman who had been denied abortion at one hospital because of state statute could not adequately represent tangential interest of another pregnant woman who had been denied abortion at another hospital, motion by latter woman to intervene in class action attacking state abortion statute would be denied.

16. Abortion ⇐1

Where court declared state abortion statute invalid to extent it limited reasons for granting of abortion but upheld requirement of approval by hospital committee before abortion is performed, any action of committee in adopting same reasons for permitting abortion as had been declared invalid was itself invalid.

Margie Pitts Hames, Tobiane Schwartz, Elizabeth Rindskopf, Bettye Kehrer, Atlanta, Ga., for plaintiffs.

Arthur K. Bolton, Atty. Gen., Tony H. Hight, Asst. Dist. Atty., Atlanta, Ga., for Slaton.

Ralph H. Witt, Atlanta, Ga., for Jenkins.

Ferdinand Buckley, Atlanta, Ga., for unborn child of Mary Doe.

Before MORGAN, Circuit Judge, and SMITH and HENDERSON, District Judges.

PER CURIAM.

This is an action for declaratory and injunctive relief brought pursuant to 28 U.S.C.A. §§ 2201 and 2202, and 42 U.S.C. A. § 1983 and 28 U.S.C.A. § 1343. It is a class action attacking Ga. Code Ann. § 26–1201 et seq. (1969) Georgia's "Abortion Act."

Plaintiffs claim to represent four sub-classes: pregnant women, single or married, wishing legal abortions; licensed physicians who wish to perform or counsel performance of legal abortions; registered nurses who desire to participate in performing or counsel

performance of legal abortions; and ministers and social workers who wish to be free to advise abortion in counselling pregnant women.

Plaintiffs seek an order declaring Georgia's Abortion Statute unconstitutional and enjoining its enforcement on various grounds:

(1) the Statute is unconstitutionally vague and indefinite on its face and as applied, failing to provide sufficient warning of the conduct proscribed, in violation of the Due Process Clause of the Fourteenth Amendment to the United States Constitution;

(2) Georgia's Abortion Statute unconstitutionally abridges a woman's right to decide to terminate an unwanted pregnancy, in restricting that fundamental liberty without an overriding compelling state interest;

(3) the Statute unconstitutionally restricts the right of the physicians, nurses, ministers and social workers to practice their professions;

(4) Georgia's Abortion Statute produces discrimination against poor and non-white women in violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

PENDING MOTIONS

Arthur K. Bolton, sued in his official capacity as Attorney General of Georgia has moved for an order dismissing the claim against him on the ground that no relief could be granted against him since he is not charged generally with the enforcement, application or administration of the Georgia criminal statutes.

[1] As plaintiffs observe, Article VI, § X, Par. II of the Georgia Constitution, Ga. Code Ann. § 2-4502 (1933) requires the Attorney General to represent the State in any civil or criminal case when required by the Governor. Furthermore, he may be required to give the Governor advisory opinions on the abortion statute. Ga. Code Ann. § 40-1602 (1933). Finally, the Attorney General is head of the Department of Law, which is vested with authority and jurisdiction in all matters of law relating to governmental departments, boards and agencies. Ga. Code Ann. § 40-1614 (1943). The Attorney General has sufficient connection with enforcement of the statutes attacked to justify retaining him as a party.[1] See Arneson v. Denny, 25 F.2d 993 (W.D.Wash.1928); Jackson v. Colorado, 294 F.Supp. 1065, 1072 (D.Colo.1968); James v. Almond, 170 F.Supp. 331, 341-342 (E.D.Va.1959); International Longshoremen's & Warehousemen's Union v. Ackerman, 82 F. Supp. 65, 124 (D.Haw.1948), rev'd on other grounds 187 F.2d 860 (9th Cir. 1951); Bevins v. Prindable, 39 F.Supp. 708, 710 (E.D.Ill.1941). Accordingly, that motion is denied.

The Attorney General has also objected to interrogatories which plaintiffs served for answer by a witness, Roger Rochat, M. D. In view of the disposition of this case made below, no ruling on this motion is necessary.

The motion of Ferdinand Buckley, Esquire, for reconsideration of the revocation of his appointment as guardian ad litem will be dealt with in connection with the discussion under MERITS below.

The motion of the National Legal Program on Health Problems of the Poor to submit a brief as *amicus curiae* is granted.

The defendant Lewis R. Slaton, District Attorney of Fulton County, filed motions seeking orders requiring disclosure of plaintiff's identity, granting a continuance for discovery for a reasonable time thereafter, and requiring plaintiff to submit to a physical and mental examination. In view of the reasons for which it is held that the complaint of this plaintiff presented a justi-

1. The Court is also aware that the Attorney General regularly interprets State criminal laws and decisions in published opinions and circulars to State judges and law enforcement officers.

ciable controversy, these motions are directed toward obtaining information which is not relevant to the case. Accordingly, they are denied.

JURISDICTION

A. *Substantial Constitutional Question.*

A three-judge court was convened pursuant to 28 U.S.C.A. §§ 2281 and 2284. Such action is proper where plaintiffs attack the constitutionality of a state statute, raising a substantial constitutional question, and seek equitable relief against its enforcement. Idlewild Bon Voyage Liquor Corp. v. Epstein, 370 U.S. 713, 715, 82 S.Ct. 1294, 8 L.Ed.2d 794 (1962).

Plaintiffs here attack the constitutionality of Ga. Code Ann. § 26-1201 et seq. (1969) on the grounds that it infringes rights protected by various Amendments to the United States Constitution. They seek an injunction against enforcement. In light of recent cases on the subject of the Constitutional right to an abortion, this Constitutional question appears substantial. *See* Roe v. Wade, 314 F.Supp. 1217 (N.D.Tex., June 17, 1970); Doe v. Randall, 314 F.Supp. 32 (D.Minn., May 19, 1970); Doe v. Scott, 310 F.Supp. 688 (N.D.Ill., March 27, 1970); Babbitz v. McCann, 310 F.Supp. 293 (E.D. Wis.1970); United States v. Vuitch, 305 F.Supp. 1032 (D.D.C.1969), app. docketed, No. 1155 (February 5, 1970); California v. Belous, 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), cert. den. 397 U.S. 915, 90 S.Ct. 920, 25 L. Ed.2d 96 (1970).

B. *Justiciability.*

Standing

By motion to dismiss, Lewis R. Slaton, District Attorney of Fulton County, contends that all plaintiffs other than Mary Doe lack standing to maintain this action. The basis for the claims of these plaintiffs is that because they are not free to perform or counsel the obtaining of abortions, they are unconstitutionally restricted in the practice of their professions.

There are certainly instances in which any of these plaintiffs would have standing to claim a constitutional right to practice his profession, and infringement thereof. For instance, few would dispute that a social worker being prosecuted for conspiracy because he (or she) counselled obtaining an abortion, and referred the client to a physician for the abortion, would have standing to seek a declaratory judgment of his (or her) asserted constitutional right and infringement thereof. *See* Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L. Ed.2d 510 (1965).

But absent prosecution or indictment, that these plaintiffs do have standing is more difficult to see. Whether their claim is otherwise justiciable is irrelevant. Flast v. Cohen, 392 U.S. 83, 100 n. 21, 99 S.Ct. 1942, 20 L.Ed.2d 947 (1968). The sole issue is whether there is a logical link between the status they assert (physician, nurse) and the claim they seek adjudicated, or between their status and both the type of enactment attacked and the nature of the constitutional infringement alleged. 392 U.S. at 102, 88 S.Ct. 1942.

[2] Under either test, all the plaintiffs have standing. As physicians, nurses, ministers or social workers they attack a criminal statute potentially applicable to them, on the grounds that it unconstitutionally restricts their right to practice. Accordingly, the motion to dismiss for lack of standing is denied.

Collision of Interests

[3] Article III of the United States Constitution limits the jurisdiction of the federal courts to cases and controversies. And it is well established that in actions for declaratory judgments, a District Court may not render an advisory opinion on the constitutionality of a state statute. Rather there must be "exigent adversity," an actual controversy in which the constitutionality of the statute is drawn into question in a truly adversary context. *See* Golden v. Zwickler, 394 U.S. 103, 108, 89 S.Ct. 956, 22

L.Ed.2d 113 (1969); Poe v. Ullman, 367 U.S. 497, 81 S.Ct. 1752, 6 L.Ed.2d 989 (1961); United Public Workers of America v. Mitchell, 330 U.S. 75, 89, 67 S.Ct. 556, 91 L.Ed. 754 (1947).

Most akin to the instant case is Poe v. Ullman, 367 U.S. 497, 81 S.Ct. 1752, 6 L.Ed.2d 989 (1961). There, a married couple, a married woman and their physician sought a declaratory judgment that Connecticut's statutes prohibiting the use of contraceptive devices and the giving of medical advice in the use of such devices violated plaintiffs' Fourteenth Amendment rights, depriving them of life and liberty without due process of law. None of the plaintiffs had been indicted or prosecuted under the statutes. There had been only one recorded prosecution for violation of the statutes in the seventy-five years since their enactment, and that single instance occurred twenty years before the declaratory judgment action was brought. The Supreme Court suggested that the lack of a pending prosecution or immediate threat of such prosecution against the particular plaintiffs made the claims non-justiciable, citing United Public Workers of America v. Mitchell, 330 U.S. 75, 67 S.Ct. 556, 91 L.Ed. 754 (1947). Poe v. Ullman, 367 U.S. at 501, 81 S.Ct. 1752. But the Justices went on to find that the lack of recorded prosecutions, the unchallenged, open, ubiquitous public sales of contraceptive devices showed a deeply embedded State policy against enforcement, amounting to a tacit agreement not to prosecute violators of the statutes. The majority therefore held:

> "It is clear that the mere existence of a state penal statute would constitute insufficient grounds to support a federal court's adjudication of its constitutionality in proceedings brought against the State's prosecuting officials if real threat of enforcement is wanting." 367 U.S. at 507, 81 S.Ct. at 1758.

However, these three cases seem precedent for the proposition that in the absence of a pending or threatened indictment or prosecution of the particular plaintiffs bringing a declaratory judgment action, a federal court cannot consider the constitutionality of the challenged criminal statute.

However in 1968, the Supreme Court decided Epperson v. Arkansas, 393 U.S. 97, 89 S.Ct. 266, 21 L.Ed.2d 228 (1968), in which a public school teacher argued that the Arkansas statute prohibiting the teaching of evolution was unconstitutional. There was no pending or threatened indictment or prosecution against the teacher. There was no record of any prosecutions under the challenged statute. The teacher's dilemma was solely that (1) the new biology textbooks she was supposed to use in the approaching term contained a chapter on evolution, and (2) her action for a declaratory judgment in state court, granted on the trial level, had been reversed by the Arkansas Supreme Court. The United States Supreme Court majority reached the merits and reversed the decision of the Arkansas Supreme Court in an opinion which summarily brushed aside the question of justiciability. 393 U.S. at 101-102, 89 S.Ct. 266. Apparently, then, the majority felt that the appeal presented a "substantial controversy * * * of sufficient immediacy and reality." Golden v. Zwickler, 394 U.S. 103, 108, 89 S.Ct. 956, 959-960 (1969).

In the instant case, the plaintiff Mary Doe alleges that having properly applied to the Abortion Committee of Grady Memorial Hospital for a legal therapeutic abortion allowed by Ga. Code Ann. § 26-1202 (1969), she was denied an abortion solely on the grounds that her present situation did not come within the terms of Ga. Code Ann. § 26-1202(a) (1) (1969).

Georgia's Abortion Act defines a criminal abortion as the act performed by a person who administers a substance or uses an instrument or other means with intent to produce a miscarriage or abortion. Ga. Code Ann. § 26-1201 (1969). However, Ga. Code Ann. § 26-1202(a) establishes three circumstances

under which an abortion shall not be considered a criminal abortion. And Ga. Code Ann. § 26-1202(b) (1969) prescribes procedure which *must* be followed if an abortion is to be authorized by or performed under 1202(a).

Ga. Code Ann. § 26-1202(b) (1969) provides in relevant part:

"No abortion is authorized or shall be performed under this section unless each of the following conditions is met:

* * * * * *

(5) The performance of the abortion has been approved in advance by a committee of the medical staff of the hospital in which the operation is to be performed. This committee must be one established and maintained in accordance with the standards promulgated by the Joint Commission on the Accreditation of Hospitals, and its approval must be by a majority vote of a membership of not less than three members of the hospital's staff; the physician proposing to perform the operation may not be counted as a member of the committee for this purpose."

[4, 5] Thus, the denial of plaintiff's application for an abortion, on the grounds alleged, was not the decision of a private physician declining to render professional services, occasioned by the mere existence of Georgia's Abortion Act. The statute confers upon the hospital committee power to grant or deny abortions. A decision denying an application for abortion on the ground that the woman's situation does not fall within one of the three enumerated exceptions is an exercise of that power, which allegedly violated plaintiff's constitutional rights. To this extent then, this statute has been invoked against the plaintiff Mary Doe, causing an alleged constitutional deprivation. Here, there has been actual interference with a claimed constitutional right by the decision of a body which the State has vested with power to grant or deny legal abortions. These circumstances put plaintiff and the defendants on opposite sides of a very real and lively controversy, amenable to judicial resolution.

Accordingly, it appears that Mary Doe's complaint, in this context, presents a justiciable controversy. Since the claims of the other plaintiffs do not stand in such a posture, the Attorney General's motion to dismiss must be granted to that extent.

C. *Exhaustion.*

[6] There is no merit to the defendant Slaton's motion to dismiss for failure to exhaust state remedies. It does not appear that there are any administrative remedies for the denial by a hospital committee of an application for an abortion. And however desirable such a requirement might be for orderly judicial administration, there is no requirement that a litigant in federal court exhaust state judicial remedies, where he is asserting a claim in proceedings other than *habeas corpus* involving a subject over which the federal and state courts have concurrent jurisdiction. As will appear below, the instant case does not involve granting injunctive relief.

THE MERITS

[7] Plaintiff asserts that certain cases leading up to and following Griswold v. Connecticut, 381 U.S. 479, 85 S. Ct. 1678, 14 L.Ed.2d 510 (1965) establish a Constitutional right to privacy broad enough to encompass the right of a woman to terminate an unwanted pregnancy in its early stages, by obtaining an abortion. *See* Stanley v. Georgia, 394 U.S. 557, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969); Loving v. Virginia, 388 U. S. 1, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967); Skinner v. Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942); Olmstead v. United States, 277 U.S. 438, 478, 48 S.Ct. 564, 72 L.Ed. 944 (1928) (dissenting opinion of Mr. Justice Brandeis); Pierce v. Society of Sisters, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925); Meyer v. Nebraska, 262 U.S. 390, 43 S.Ct. 625, 67 L.Ed. 1042 (1923). While the Court agrees that the breadth

of the right to privacy encompasses the decision to terminate an unwanted pregnancy, we are unwilling to declare that such a right reposes unbounded in any one individual. Rather, we are of the view that although the state may not unduly limit the reasons for which a woman seeks an abortion, it may legitimately require that the decision to terminate her pregnancy be one reached only upon consideration of more factors than the desires of the woman and her ability to find a willing physician.

In Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), the Supreme Court held that the decision to use contraceptive devices is an aspect of a relationship lying within a penumbral zone of privacy created by several fundamental constitutional guarantees, and that a state law forbidding the use of such devices unduly invades that area of protected freedoms with maximum destructive effect upon that relationship. 381 U.S. at 485, 85 S.Ct. 1678. In a concurring opinion, Mr. Justice Goldberg differed with the majority only to the extent stipulating that the right to marital privacy is encompassed in his concept of personal liberty because of the Ninth Amendment, rather than because of penumbral emanations of specific constitutional guarantees.

[8] For whichever reason, the concept of personal liberty embodies a right to privacy which apparently is also broad enough to include the decision to abort a pregnancy.[2] Like the decision to use contraceptive devices, the decision to terminate an unwanted pregnancy is sheltered from state regulation which seeks broadly to limit the reasons for which an abortion may be legally obtained. However, unlike the decision to use contraceptive devices, the decision to abort a pregnancy affects other interests than those of the woman alone, or even husband and wife alone.

[9] Once conception takes place and an embryo forms, for better or for worse the woman carries a life form with the *potential* of independent human existence.[3] Without positing the existence of a new being with its own identity and federal constitutional rights, we hold that once the embryo has formed, the decision to abort its development cannot be considered a purely private one affecting only husband and wife, man and woman.

A potential human life together with the traditional interests in the health, welfare and morals of its citizenry under the police power grant to the state a legitimate area of control short of an invasion of the personal right of initial decision.

[10] The whole thrust of the present Georgia statute[4] is to treat the problem as a medical one. Such approach is reasonable and seemingly sound inasmuch as medical practitioners are in the best position by virtue of training to judge concurrently the basis as well as the risk inherent in such a decision. In this respect, the state moreover has a legitimate interest in seeing to it that the decisions—personal and medical—is not one

2. We see no connection between this theory and the claimed unlimited right of a woman "to use her body in any way she wishes" read into Griswold by some. There are obvious limitations to the latter such as self abuse, *e. g.* disease, drugs, suicide, etc. and the rights of others in which the state clearly has an interest. Any such theory in its ultimate is flatly rejected.

3. This view of the impact of conception on the decision not to have children implies that the distinction between a quick and unquick fetus, and even that between embryo and fetus is not relevant here. And since the Court does not postulate the existence of a new being with federal constitutional rights at any time during gestation, the motion of Mr. Ferdinand Buckley for reconsideration of the order revoking his appointment as guardian *ad litem* for the embryo (or fetus) is denied. Mr. Buckley's motion to intervene in such capacity is also denied. However, he has the Court's appreciation for his participation in this litigation as *amicus curiae*.

4. Apparently patterned after the American Law Institute, Model Penal Code § 230.3 (Proposed Official Draft, 1962)

undertaken lightly and without careful consideration of all relevant factors, whether they be emotional, economic, psychological, familial or physical. For example, the legislature might require any number of conditions such as consultation with a licensed minister or secular guidance counselor as well as the concurrence of two licensed physicians or any system of approval related to the quality and soundness of the decision in all its aspects. It certainly has a clear right to circumscribe a decision made by a woman alone or by a woman and a single physician and to guard against the establishment of transient "abortion mills" by the occasional opportunistic or unethical practitioner and the concomitant dangers to his patrons and the public. Such controls and requirements, so long as they do not restrict the reasons for the initial decisions and do not violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment, are properly within the sphere of legislative discretion. In that respect, where abortions may be obtained only from licensed physicians and surgeons, and only after psychiatric consultation, the mere fact that physicians and psychiatrists are more accessible to rich people than to poor people, making abortions more available to the wealthy than to the indigent, is not in itself a violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution. *Cf.* Dandridge v. Williams, 397 U.S. 471, 90 S.Ct. 1153, 25 L.Ed.2d 491 (1970); MacQuarrie v. McLaughlin, 294 F.Supp. 176 (D.Mass. 1968), aff'd 394 U.S. 456, 89 S.Ct. 1224, 22 L.Ed.2d 417 (1969).

Moreover, there is an overriding interest in the manner of performance as well as the quality of the final decision to abort. Obvious need for control through licensing, sanitation requirements and proper medical standards in the execution of a legal abortion are examples. Again such decisions address themselves to legislative decision based upon informed judgment.

[11] Having decided that the reasons for an abortion may not be proscribed, but that the quality of the decision as well as the manner of its execution are properly within the realm of state control, the present statute must be examined in such light.

Rather than regulating merely the quality of the decision to have an abortion, and the manner of its performance, the Georgia statute also limits the number of reasons for which an abortion may be sought. This the State may not do, because such action unduly restricts a decision sheltered by the Constitutional right to privacy. *See* Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); California v. Belous, 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), cert. den. 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970). The question becomes a matter of statutory overbreadth.

[12] Based upon the above, the court finds the following portions of Georgia Code § 26–1202 to be in violation of the constitutional rights of petitioner:

A. Section (a) beginning with the word "because" on line 5 and through subsection (a) (3) in its entirety.

B. Section (b) subsection (3) beginning with the word "because" on line 6 and through the end of said subsection.

C. Section (b) subsection (6) in its entirety.

D. Section (c) in its entirety.

There being no showing to the contrary, the court further finds the remainder of said Code § 26–1202 to constitute a proper exercise of state power within the context of this opinion.[5]

5. It is not thereby implied that those provisions constitute the only or best means of state control. On the whole, the present system appears unnecessarily cumbersome, a potential hazard under due process and equal protection considerations.

An appropriate formal declaratory judgment may be presented upon request of any party.

ABSTENTION

[13] It is recognized that there is no pending state court proceeding against which the injunction prayed by plaintiff would operate. Nevertheless, the request for injunctive relief is denied, on the same basis as such a prayer would be denied were a state proceeding actually in progress:

> "* * * the vindication of the defendant's federal rights is left to the state courts except in the rare situations where it can be clearly predicted * * * that those rights will inevitably be denied by the very act of bringing the defendant to trial in the state court." City of Greenwood v. Peacock, 384 U.S. 808, 828, 86 S.Ct. 1800, 1812, 16 L.Ed.2d 944 (1968).

However under the authority of Zwickler v. Koota, 389 U.S. 241, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967), the Court has proceeded to issue the declaratory relief, in spite of its unwillingness to broadly enjoin future prosecutions under the Act. Accordingly, plaintiff's request for a declaratory judgment is hereby granted. Judgment shall issue in the form described above.

It is so ordered.

SUPPLEMENTAL OPINION

Since the Court's opinion of July 31, 1970, several motions have been filed necessitating this opinion and order.

MOTION OF AMICUS CURIAE

Ferdinand Buckley filed a motion on September 3, 1970, to alter or amend the Court's judgment of August 25, 1970, to rule on several of his earlier motions and prayers. Accordingly, that judgment is hereby amended in the following (See FN) respect:

Mr. Buckley's motion for reconsideration of the order revoking his appointment as guardian *ad litem* for the embryo (or fetus), and his motion to intervene in any representative capacity on behalf of the embryo or fetus is denied. This ruling makes it unnecessary, and the Court declines, to rule on the prayers in the answer and counterclaim Mr. Buckley filed before revocation of his appointment as guardian *ad litem*.

MOTIONS OF JANE ROE

Jane Roe petitions for leave to intervene as a plaintiff, moves for a temporary restraining order, and asks that the Court clarify and enforce its opinion of July 31, 1970. Said petition, and accordingly also the motion and the request are denied for two reasons.

[14] First, the Court is informed by counsel for all concerned that Georgia Baptist Hospital has reconsidered its earlier decision and subsequently granted Jane Roe's application for an abortion. Said action renders the petition of Jane Roe moot, there now being no sufficient collision of interests between Jane Roe and the defendants.

[15] Second, Jane Roe's petition to intervene makes it clear that her controversy was with Georgia Baptist Hospital, and only tangentially with the defendants in this case. Under such circumstances there is no showing that Mary Doe—representing the class of pregnant women denied abortions because of the Georgia statute attacked—could not adequately represent the tangential interest of Jane Roe in this action. *See* Allen Calculators, Inc. v. National Cash Register Co., 322 U.S. 137, 141, 64 S.Ct. 905, 88 L.Ed. 1188 (1944); Durkin v. Pet Milk Co., 14 F.R.D. 374 (W.D.Ark.1953).

In spite of the above, the motion presents an aspect of the case which justifies some amplification of the previous declaratory judgment. The court concludes that this should be done by way of amendment sua sponte. Rule 60(b)(6); Klapprott v. United States, 335 U.S. 601, 69 S.Ct. 384, 93 L.Ed. 266 (1948); Bros, Incorporated v. W. E.

Grace Mfg. Co., 320 F.2d 594 (5th Cir. 1963).

The problem relates to the role and function of the "abortion committees" in the several hospitals. Ga. Code § 26-1202b(5). The thrust of the original opinion was to carry out the apparent intent of the Georgia legislature by making the ultimate decision on individual abortions a medical one. However, in line with constitutional principles, the ultimate decision cannot be restricted to the three reasons stated in the statute. This left the abortion committee free to decide whether an abortion was "necessary" on the broader medical basis, namely, the totality of circumstances surrounding each patient.

[16] From the motion it is apparent that those committees who have voluntarily adopted the standards promulgated by the American College of Obstetricians and Gynecologists as controlling have placed themselves in the position of being restricted by the same reasons stated in the statute.[1] What is denied directly cannot be accomplished indirectly. It follows that the abortion committees cannot be limited to the stated reasons as the sole basis for approval of an individual abortion, nor can they so limit themselves by the adoption of such standards. Any such action by a hospital committee is declared to be an unconstitutional exercise of delegated power.

In sum, the statutory processes of approval are left standing. The patient is required to obtain the approval of (1) the certifying physician, (2) the two consulting physicians, and (3) the abortion committee of the admitting hospital. Failure to obtain approval at any level necessarily precludes abortion on that application. A majority of the abortion committee shall control its action, whether for approval or for disapproval.

To the extent stated herein, the original opinion is modified.

It is so ordered.

1. The Georgia statute requires the hospital to apply standards promulgated by the Joint Commission on the Accreditation of Hospitals. No such restrictive reasons for approval of an abortion are contained therein. However, the voluntary standards promulgated by the American College of Obstetricians and Gynecologists in part limit the grounds for abortion to the three stated statutory reasons: injury to health of the mother; danger of grave physical or mental defect to the child; and pregnancy due to rape. Any such limiting restrictions, as seen, must fail. Likewise, lack of consent by the husband, while it may freely be considered by the committee, may not be automatically established as an absolute bar.
By way of additional comment, good faith administration of the statute as now constituted would prohibit a committee from secretly restricting abortions to those statutory reasons, which the court has already deleted. To the contrary, all relevant factors should be considered and an informed medical judgment made.

458 P.2d 194

The PEOPLE, Plaintiff and Respondent,

v.

Leon Phillip BELOUS, Defendant and Appellant.

Cr. 12739.

Supreme Court of California, In Bank.

Sept. 5, 1969.

Rehearing Denied Oct. 1, 1969.

cert. denied, 397 U.S. 915 (1970)

Defendant was convicted in the Superior Court, Los Angeles County, John G. Barnes, J., of abortion and conspiracy to commit an abortion, and he appealed. The Supreme Court, Peters, J., held that statute making a person who performs abortion punishable unless abortion is necessary to preserve mother's life as statute read before amended in 1967 was invalid where term "necessary to preserve" was not susceptible to a construction which, while satisfying legislative intent, was sufficiently certain to satisfy due process requirements without improperly infringing on fundamental constitutional rights of mother to life and to choose whether to bear children, and convictions of abortion and conspiracy to commit abortion could not stand.

Judgment reversed with directions to dismiss indictment.

Burke, McComb, and Sullivan, JJ., dissented.

1. Criminal Law ⇐13

Requirement of certainty in legislation is greater where criminal statute is a limitation on constitutional rights, but mathematical certainty is not required.

2. Constitutional Law ⇐83(1)

A woman has the fundamental right to choose whether to bear children.

3. Constitutional Law ⇐82

That a fundamental right is not enumerated in either Federal or State Constitutions is no impediment to its existence.

4. Constitutional Law ⇐38

Fact that abortion law was valid when first enacted in 1850 would not resolve issue of whether law was presently constitutionally valid. West's Ann.Pen.Code, § 274.

5. Constitutional Law ⇐253

Delegation of decision-making power to a directly involved individual violates Fourteenth Amendment. U.S.C.A.Const. Amend. 14.

6. Abortion ⇐1
Constitutional Law ⇐258

Statute making a person who performs abortion punishable unless abortion is necessary to preserve mother's life as statute read before amended in 1967 was invalid where term "necessary to preserve" was not susceptible to a construction which, while satisfying legislative intent, was sufficiently certain to satisfy due process requirements without improperly infringing on fundamental constitutional rights of mother to life and to choose whether to bear children, and convictions of abortion and conspiracy to commit abortion could not stand. West's Ann.Pen.Code, §§ 182, 274, 276; West's Ann.Health & Safety Code, §§ 25950–25954, 25951(a, b), (c) (1, 2), 25952(c); U.S.C.A.Const. Amend. 14.

A. L. Wirin, Fred Okrand, Zad Leavy and Beilenson & Leavy, Los Angeles, for defendant and appellant.

Thomas C. Lynch, Atty. Gen., William E. James, Asst. Atty. Gen., and Phillip G. Samovar, Deputy Atty. Gen., for plaintiff and respondent.

McCutchen, Doyle, Brown & Enersen, Burnham Enersen, Robert A. Blum, Terry J. Houlihan, San Francisco, Norma G. Zarky, Howard H. Jewel, Oakland, Paul N. Halvonik, San Francisco, William Kelly, Barbara N. Armstrong, Charles E. Beardsley, Los Angeles, George A. Blackstone, A. Stevens Halsted, Jr., Roderick M. Hills, Leonard S. Janofsky, Los Angeles, Herma Hill Kay, Berkeley, Frederick R. McBrien, Charles T. Munger, Stuart T. Peeler, Samuel O. Pruitt, Jr., Charles E. Rickershauser, Jr., Graham L. Sterling, Charles E. Stimson, Jr., Los Angeles, and Francis M. Wheat as amici curiae on behalf of defendant and appellant.

Charles H. Clifford, Walter R. Trinkaus, J. J. Brandlin, Los Angeles, Thomas J. Arata, Santa Rosa, Richard D. Andrews, Fresno, Cyril A. Coyle, Sacramento, Mazzera, Snyder & DeMartini, Stockton, John F. Duff, San Francisco, William R. Kennedy, Richard G. Logan, Oakland, and Curran, Golden, McDevitt & Martin, San Diego, as amici curie on behalf of plaintiff and respondent.

PETERS, Justice.

Dr. Leon Phillip Belous was convicted in January 1967, after a jury trial, of abortion, in violation of section 274 of the Penal Code, and conspiracy to commit an abortion, in violation of section 182 of the Penal Code, both felonies. The court suspended proceedings, imposed a fine of $5,000, and placed Dr. Belous on probation for two years. He appeals from the order granting probation.

Dr. Belous is a physician and surgeon, licensed since 1931 to practice medicine in the State of California, and specializing in obstetrics and gynecology. He has been on the attending staff of the gynecology department of Cedars of Lebanon Hospital in Los Angeles since 1931, is a fellow of the Los Angeles Gynecology and Obstetrical Society, the American College of Obstetrics and Gynecology, the Abdominal Surgical Society, and the Geriatric Society, and a member of the American Board of Obstetrics and Gynecology. He is on the Board of Directors of the California Committee on Therapeutic Abortion, an organization which seeks to liberalize abortion laws. He is considered by his associates to be an eminent physician in his field.

The prosecution's witnesses, a young woman and her husband, Cheryl and Clifton, testified to the following:

In 1966, Cheryl, then unmarried, believed she was pregnant. A family physician had

given her pills which would induce menstruation if she were not pregnant, but the pills did not work. She and Clifton had sometime earlier seen Dr. Belous on television, advocating a change in the California abortion laws. They had never heard of Dr. Belous before. Clifton obtained the doctor's phone number from the television station and phoned Dr. Belous; he explained the problem and that they both were "pretty disturbed," and at their "wits' end" and asked for Dr. Belous' help. Dr. Belous told him there was nothing he could do, but Clifton "continued pleading," and threatened that Cheryl would go to Tijuana for an abortion. Finally the doctor agreed to see them at his office.

Dr. Belous examined Cheryl at his Beverly Hills office and confirmed that she was possibly pregnant. Cheryl was otherwise in good health. The visit lasted about 45 minutes and was very emotional. Both Clifton and Cheryl pleaded for help, cried, insisted they were going to have an abortion "one way or another." The doctor lectured them on the dangers of criminal abortions, and Tijuana abortions in particular, and suggested that they get married. He insisted he did not perform abortions. He refused to recommend anyone in Tijuana. Finally, in response to their pleadings, Dr. Belous gave them a piece of paper with a Chula Vista phone number. He told them an abortion would cost about $500. He gave Cheryl a prescription for some antibiotics and instructed her to return for an examination.

Dr. Belous testified that he was very familiar with the abortion business in Tijuana. He had visited the clinics there to learn about conditions and knew that women who went to Tijuana were taking their lives in their hands. He met Karl Lairtus while in Tijuana and knew from personal observation that Lairtus, licensed to practice in Mexico but not in California, was performing skilled and safe abortions in Mexico. Lairtus wanted to obtain a California license, and sought out Belous' help on a number of occasions. When Lairtus moved from Mexico to Chula Vista, he gave Dr. Belous his address and phone number. When Lairtus moved to Los Angeles, he gave the doctor a Hollywood address, and made it known to the doctor that he was performing abortions. It was Lairtus' number that Belous gave to Cheryl and Clifton. Although he had given out Lairtus' number before, in similar situations, where distraught pregnant women insisted they would do anything, Dr. Belous had no idea how many women actually went to Lairtus.

Cheryl and Clifton made arrangements with Lairtus, and went to the address which Lairtus gave them on the phone. After the abortion was performed, while Cheryl was resting, the police, having been advised by another woman that Lairtus was performing abortions at that address, came to his apartment, followed another couple into the apartment and arrested Lairtus. They found two notebooks containing women's names, ages, dates of last menstruation, and physician's names, including Dr. Belous' name, which the police interpreted as the referring doctor with whom Lairtus was to split his fees. On the basis of this information, Dr. Belous was arrested at his office. Lairtus pleaded guilty. At Dr. Belous' trial, he testified that, although not solicited, he sent Dr. Belous about $100 as a professional courtesy in about half the cases that he had performed abortions on Dr. Belous' patients. Dr. Belous denied receiving any money from Lairtus.

The substance of Dr. Belous' defense was that he gave Lairtus' phone number to Cheryl and Clifton only because he believed that they would, in fact, do anything to terminate the pregnancy, which might involve butchery in Tijuana or self-mutilation; that in face of their pleading and tears, he gave out the phone number of someone whom he knew to be a competent doctor, although unlicensed in this state. The doctor believed that if the young couple carried out their threats, Cheryl's very life was in danger.

Section 274 of the Penal Code, when the conduct herein involved occurred, read: "Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life, is punishable by imprisonment in the State prison not less than two nor more than five years."

The statute was substantially unchanged since it was originally enacted in 1850.[1] In 1967, the statute was amended and sections 25950 through 25954 ("Therapeutic Abortion Act") added to the Health and Safety Code. The act extends the lawful grounds for obtaining an abortion.[2] Section 274 is directed towards the abortionist. Under section 275 of the Penal Code (also amended by the Therapeutic Abortion Act), a woman who solicits or submits to an abortion is punishable by up to five years' imprisonment; similarly, under section 276, any person who solicits a woman to submit to an abortion is punishable by up to five years' imprisonment.

We have concluded that the term "necessary to preserve" in section 274 of the Penal Code is not susceptible of a construction that does not violate legislative intent and that is sufficiently certain to satisfy due process requirements without improperly infringing on fundamental constitutional rights.

"The requirement of a reasonable degree of certainty in legislation, especially in the criminal law, is a well established element of the guarantee of due process of law. 'No one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the State commands or forbids. * * * "a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law."' Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 83 L.Ed. 888; see also Connally v. General Const. Co., 269 U.S. 385, 391, 46 S.Ct. 126, 70 L.Ed. 322. Such also is the law of the State of California. People v. McCaughan, 49 Cal.2d 409, 414, 317 P.2d 974.

[1] "The required meaning, certainty and lack of ambiguity may appear on the face of the questioned statute or from any demonstrably established technical or common law meaning of the language in ques-

1. Stats.1850, ch. 99, § 45, at p. 233: "[E]very person who shall administer or cause to be administered or taken, any medicinal substances, or shall use or cause to be used any instruments whatever, with the intention to procure the miscarriage of any woman then being with child, and shall be thereof duly convicted, shall be punished by imprisonment in the State Prison for a term not less than two years, nor more than five years: *Provided*, that no physician shall be affected by the last clause of this section, who, in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life."

2. Penal Code, section 274, as amended reads: "Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, * * * *except as provided in the Therapeutic Abortion Act * * * of the Health and Safety Code*, is punishable by imprisonment in the state prison * * *." (Stats.1967, ch. 327, § 3, at p. 1523; italics added.)

The Therapeutic Abortion Act (Health & Saf.Code, §§ 25950–25954) authorizes abortions "only" if the abortion takes place in an accredited hospital (§ 25951, subd. (a)); the abortion is approved by a hospital staff committee consisting of at least three licensed physicians and surgeons (§ 25951, subd. (b)); and there is "substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother" (§ 25951, subd. (c) (1)); the pregnancy resulted from rape or incest (§ 25951, subd. (c) (2)); or the woman is under 15 years of age (§ 25952, subd. (c)).

tion. People v. McCaughan, *supra*, 49 Cal. 2d 409, 414, 317 P.2d 974; Lorenson v. Superior Court, 35 Cal.2d 49, 60, 216 P.2d 859." (In re Newbern, 53 Cal.2d 786, 792, 3 Cal.Rptr. 364, 368, 350 P.2d 116, 120.) The requirement of certainty in legislation is greater where the criminal statute is a limitation on constitutional rights. (See Smith v. California (1959) 361 U.S. 147, 151, 80 S.Ct. 215, 4 L.Ed.2d 205.) On the other hand, mathematical certainty is not required; "some matter of degree" is involved in most penal statutes. (Nash v. United States (1913) 229 U.S. 373, 377, 33 S.Ct. 780, 57 L.Ed. 1232.)

Dictionary definitions and judicial interpretations fail to provide a clear meaning for the words, "necessary" or "preserve." There is, of course, no standard definition of "necessary to preserve," and taking the words separately, no clear meaning emerges. "Necessary" is defined as: "1. Essential to a desirable or projected end or condition; not to be dispensed with without loss, damage, inefficiency, or the like; * * *" (Webster's New International Dictionary (2d ed.), unabridged.) The courts have recognized that "'necessary' has not a fixed meaning, but is flexible and relative." (Westphal v. Westphal, 122 Cal. App. 379, 382, 10 P.2d 119, 120; see also, City of Dayton v. Borchers (Ohio Common Pleas, 1967) 13 Ohio Misc. 273, 232 N.E.2d 437, 441 ["A *necessary* thing may supply a wide range of wants, from mere convenience to logical completeness."].)

The definition of "preserve" is even less enlightening. It is defined as: "1. To keep or save from injury or destruction; to guard or defend from evil; to protect; save. 2. To keep in existence or intact; * * * To save from decomposition, * * * 3. To maintain; to keep up; * * *" (Webster's New International Dictionary, *supra*.) The meanings for "preserve" range from the concept of maintaining the status quo—that is, the woman's condition of life at the time of pregnancy—to maintaining the biological or medical definition of "life"—that is, as opposed to the biological or medical definition of "death".

Since abortion before quickening was not a crime at common law (Perkins, Criminal Law (1957) 101; Means, The Law of New York Concerning Abortion and the Status of the Foetus, 1664–1968: A Case of Cessation of Constitutionality (1968) 14 N.Y.L. F. 411, 419–422; Stern, Abortion: Reform and the Law (1968) 59 J.Crim.L.C. & P.S. 84, 85) we cannot rely on common law meanings or common law referents (see Lorenson v. Superior Court, *supra*, 35 Cal. 2d 49, 60, 216 P.2d 859; People v. Agnello, 259 Cal.App.2d 785, 790–791, 66 Cal.Rptr. 571).[3]

Various possible meanings of "necessary to preserve * * * life" have been suggested. However, none of the proposed definitions will sustain the statute.

Respondent asserts: "If medical science feels the abortion should be performed as it is necessary to preserve her life, then it may be performed; that is, unless it is performed the patient will die."

Our courts, however, have rejected an interpretation of "necessary to preserve" which requires certainty or immediacy of death. (People v. Abarbanel, 239 Cal.App. 2d 31, 32, 35, 48 Cal.Rptr. 336; People v. Ballard, 218 Cal.App.2d 295, 298, 32 Cal. Rptr. 233; People v. Ballard, 167 Cal.App. 2d 803, 807, 335 P.2d 204.) Justice Fourt, in People v. Ballard, *supra*, 167 Cal.App. 2d 803, 814, 335 P.2d 204, 212, stated: "Surely, the abortion statute (Pen.Code, § 274) does not mean by the words 'unless the same is necessary to preserve her life' that the peril to life be imminent. It ought to be enough that the dangerous condition 'be potentially present, even though its full

3. Compare United States v. Harriss (1954) 347 U.S. 612, 634, 74 S.Ct. 808, 820, 98 L.Ed. 989 (dissenting opinion): "Whoever kidnaps, steals, kills, or commits similar acts of violence upon another is bound to know that he is inviting retribution by society, and many of the statutes which define these long-established crimes are traditionally and perhaps necessarily vague."

development might be delayed to a greater or less extent. Nor was it essential that the doctor should believe that the death of the patient would be otherwise *certain* in order to justify him in affording present relief.' [Citations.]" The above language was quoted in People v. Abarbanel, *supra*, 239 Cal.App.2d 31, 34, 48 Cal.Rptr. 336.

In People v. Ballard, *supra*, 167 Cal.App. 2d 803, 813–814, 335 P.2d 204, 211, the evidence established that the woman was "extremely nervous * * * upset, had headaches, was unable to sleep, and thought that she was pregnant. She was agitated, disturbed and had many problems." (Italics omitted.) In People v. Ballard, *supra*, 218 Cal.App.2d 295, 307, 32 Cal.Rptr. 233, it was established that at the time each of the women went to the defendant doctor she was in a "bad state of health" because of self-imposed abortive practices. And in People v. Abarbanel, *supra*, 239 Cal.App.2d 31, 48 Cal.Rptr. 336, the obstetrician performed the abortion after receiving letters from two psychiatrists to the effect that abortion was indicated as necessary to save the woman's life from the "possibility" of suicide. In each of the cases the conviction was reversed.

If the fact of ill health or the mere "possibility" of suicide is sufficient to meet the test of "necessary to preserve her life," it is clear that a showing of immediacy or certainty of death is not essential for a lawful abortion. Two other jurisdictions have also rejected an interpretation of "necessary to preserve" which would require certainty or immediacy of death. (State v. Dunklebarger (1928) 206 Iowa 971, 221 N. W. 592, 596; State v. Hatch (1917), 138 Minn. 317, 164 N.W. 1017.)

After the decision in *Ballard*, the Legislature did not amend the statute to repudiate the rule suggested by that case and to establish a definition requiring certainty of death.[4]

It would be anomalous to uphold a criminal statute against a charge of vagueness by adopting a construction of the statute rejected by the courts of this state as not reflecting legislative intent unless there was a clear showing of a strong public policy or legislative intent requiring adoption of the rejected construction. No such showing has been made with regard to the construction urged by respondent.

Moreover, a definition requiring certainty of death would work an invalid abridgment of the woman's constitutional rights. The rights involved in the instant case are the woman's rights to life and to choose whether to bear children.[5] The woman's right to life is involved because childbirth involves risks of death.[6]

[2, 3] The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a "right of privacy" or "liberty" in matters related to marriage, family, and sex. (See, e. g., Griswold v. Connecticut, *supra*, 381 U.S. 479, 485, 486, 500, 85 S.Ct. 1678, 14 L.Ed.2d 510; Loving v. Virginia (1967) 388 U.S. 1, 12, 87 S.Ct. 1817, 18 L.Ed.2d 1010 [statute prohibiting interracial marriages, violative of Due Process Clause]; Skinner v. Oklahoma ex rel. Williamson (1942) 316 U.S. 535, 536, 541, 62 S.Ct. 1110, 86 L.Ed. 1655 [sterilization laws; marriage and procreation involve a "basic liberty"]; Pierce v. Society of Sisters (1925) 268 U.S. 510, 534–535, 45 S.Ct. 571, 69 L.Ed. 1070, 39 A.L.R.

4. The definitions suggested by the two *Ballard* cases and by *Abarbanel* will be discussed later in this opinion.

5. Dr. Belous' standing to raise this right is unchallenged. (Cf. Griswold v. Connecticut (1965) 381 U.S. 479, 481, 85 S.Ct. 1678, 14 L.Ed.2d 510; Barrows v. Jackson (1953) 346 U.S. 249, 257, 73 S.Ct. 1031, 97 L.Ed. 1586; Parrish v. Civil Service Commission, 66 Cal.2d 260, 264, 57 Cal.Rptr. 623, 425 P.2d 223.)

6. E. g., The maternal death rate in 1966 was 0.5 per 100,000 population and 29.1 per 100,000 births. (Statistical Abstract of the United States (1968) table 73, at p. 58, table 68, at p. 55.) In California in 1966 the maternal death rate was 2.1 per 10,000 live births. (California Statistical Abstract (1968) table E–3, at p. 67.) As to a particular pregnant woman the risk of death may be greater or lesser.

468 [prohibition against nonpublic schools; same]; Meyer v. Nebraska (1923) 262 U.S. 390, 399–400, 43 S.Ct. 625, 67 L.Ed. 1042 [prohibition against teaching children German language; same]; Perez v. Sharp, 32 Cal.2d 711, 715, 198 P.2d 17; see also Custodio v. Bauer, 251 Cal.App.2d 303, 317–318, 59 Cal.Rptr. 463.) That such a right is not enumerated in either the United States or California Constitutions is no impediment to the existence of the right. (See, e. g., Carrington v. Rash (1965) 380 U.S. 89, 96, 85 S.Ct. 775, 13 L.Ed.2d 675 [fundamental but nonenumerated right to vote]; Aptheker v. Secretary of State (1964) 378 U.S. 500, 505–506, 84 S.Ct. 1659, 12 L.Ed.2d 992 and Kent v. Dulles (1958) 357 U.S. 116, 125, 78 S.Ct. 1113, 2 L.Ed.2d 1204 [right to travel]; Bolling v. Sharpe (1954) 347 U.S. 497, 500, 74 S.Ct. 693, 98 L.Ed. 884 [right to attend federal unsegregated schools]; Otsuka v. Hite, 64 Cal.2d 596, 602, 51 Cal.Rptr. 284, 414 P.2d 412 [right to vote]; cf. Finot v. Pasadena City Bd. of Education, 250 Cal. App.2d 189, 199, 58 Cal.Rptr. 520.) It is not surprising that none of the parties who have filed briefs in this case have disputed the existence of this fundamental right.

The critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state (Shapiro v. Thompson (1969), 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600; Sherbert v. Verner (1963) 374 U.S. 398, 403, 83 S.Ct. 1790, 10 L.Ed.2d 965), whether the regulation is "necessary * * * to the accomplishment of a permissible state policy" (McLaughlin v. Florida (1964) 379 U.S. 184, 196, 85 S.Ct. 283, 290, 13 L.Ed.2d 222; see also, N.A.A.C.P. v. Button, 371 U.S. 415, 438, 83 S.Ct. 328, 9 L.Ed.2d 405; Bates v. City of Little Rock (1960) 361 U.S. 516, 527, 80 S.Ct. 412, 4 L.Ed.2d 480; Huntley v. Public Util. Comm., 69 A.C. 62, 69, 69 Cal.Rptr. 605, 442 P.2d 685; Vogel v. County of Los Angeles, 68 Cal.2d 18, 21, 64 Cal. Rptr. 409, 434 P.2d 961; People v. Woody, 61 Cal.2d 716, 718, 40 Cal.Rptr. 69, 394 P.2d 813), and whether legislation impinging on constitutionally protected areas is narrowly drawn and not of "unlimited and indiscriminate sweep" (Shelton v. Tucker (1960) 364 U.S. 479, 490, 81 S.Ct. 247, 5 L.Ed.2d 231; see also, Cantwell v. Connecticut (1940) 310 U.S. 296, 308, 60 S.Ct. 900, 84 L.Ed. 1213; In re Berry, 68 Cal.2d 137, 151, 65 Cal.Rptr. 273, 436 P.2d 273; In re Hoffman, 67 Cal.2d 845, 853–854, 64 Cal.Rptr. 97, 434 P.2d 353).

It is possible that the definition suggested by respondent, requiring that death be certain, was that intended by the Legislature when the first abortion law was adopted in 1850 and that, in the light of the then existing medical and surgical science, the great and direct interference with a woman's constitutional rights was warranted by considerations of the woman's health. When California's first anti-abortion statute was enacted, any surgical procedure which entered a body cavity was extremely dangerous. Surgeons did not know how to control infection, and mortality was high. (Haagensen & Lloyd, A Hundred Years of Medicine (1943) p. 19.) In 1867, Joseph Lister first published his findings on antiseptic surgery (*id.*, at pp. 241–242), but even in 1883 the techniques he developed were condemned (*id.*, at p. 245), and as late as 1895 were not well understood or properly applied by even leaders of the medical profession. (*Id.*, at p. 246; see also, H. Robb (1895) Aseptic Surgical Technique.)

Although development was slow, techniques of antisepsis and asepsis became major general advances in surgery at and after the turn of the century. In due course safe procedures were developed for specific operations. Curettage, used for abortion in the first trimester, became a safe, accepted and routinely employed medical technique, especially after antibiotics were developed in the early 1940's. (Douglas, Toxic Effects of the Welch Bacillus in Postabortal Infections (1956) 56 N.Y.State J.Med. 3673.) It is now safer for a woman to have

a hospital therapeutic abortion during the first trimester than to bear a child.[7]

Although abortions early in pregnancy and properly performed present minimal danger to the woman, criminal[8] abortions are "the most common single cause of maternal deaths in California." (Fox, Abortion Deaths in California (1967) 98 Am.J.Obst. & Gynec. 645, 650.) In California, it is estimated that 35,000 to 100,000 such abortions occur each year. (Fox, *supra*, at p. 645.)

The incidence of severe infection from criminal abortion is very much greater than the incidence of death. The Los Angeles County Hospital alone, for example, in 1961 admitted over 3,500 patients treated for such abortions. (Kistner, Medical Indications for Contraception: Changing Viewpoints (editorial) (1965) 25 Obst. & Gynec. 285, 286.) Possibly more significant than the mere incidence of infection caused by criminal abortions is the result of such infection. "Induced Illegal Abortion * * * is one of the important causes of subsequent infertility and pelvic disease." (Kleegman & Kaufman, Infertility in Women (1966) p. 301; see also Curtis & Huffman, Gynecology (6th ed. 1950) pp. 564–566.)[9]

Amici for appellant, 178 deans of medical schools, including the deans of all California medical schools, chairmen of medical school departments, and professors of medical schools state: "These recorded facts bring one face-to-face with the hard, shocking—almost brutal—reality that our statute designed in 1850 to protect women from serious risks to life and health has in modern times become a scourge."[10]

7. C. Tietze & H. Lehfeldt, Legal Abortion in Eastern Europe (April 1961) 175 J.A.M.A. 1149, 1152; see also V. Kolblova, Legal Abortion in Czechoslovakia (April 1966) 196 J.A.M.A. 371; K.-H. Mehland, Combatting Illegal Abortion in the Socialist Countries of Europe (1966) 13 World Med.J. 84. There are, of course, no comparable data in the United States. However, in California from November 1967 through September 1968, 3,775 therapeutic abortions were reported without a maternal death. (See Annual Report on the Implementation of the Therapeutic Abortion Act, Department of Public Health, Bureau of Maternal and Child Health (January 1969), table 1.)

The only data contrary to the conclusions above is provided by amicus for respondent, relying on Swedish data showing that maternal mortality from abortion is slightly higher than maternal mortality from giving birth. The Swedish figures are, however, explainable by the fact that abortions in Sweden are often performed during late pregnancy. (See Tietze & Lehfeldt, *supra*, 175 J.A.M.A. 1149, 1152 (e. g., in 1949, 35 percent of Swedish abortions were performed after the first trimester); Hoffmeyer, Medical Aspects of the Danish Legislation on Abortions (1965) 17 W.Res.L.Rev. 529, 544–545.)

8. The phrases "criminal abortion" and "illegal abortion" are used by the medical profession—and by legal commentators—to encompass all abortions obtained other than from a physician in an accepted surgical environment. Any use of the phrase "criminal abortion" or "illegal abortion" in this opinion merely adopts the common phraseology; no legal conclusion is intended.

9. There is considerable literature describing the experience of various hospitals with infected abortion. Hospital experience, however, can be assumed to be only the tip of the iceberg. Many badly infected women will be treated at home or in a doctor's office. (Reid, Assessment and Management of the Seriously Ill Patient Following Abortion (March 1967) 199 J.A.M.A. p. 805.) See, for hospital data, Goodno, Cushner, Molumphey, Management of Infected Abortion (1963) 85 Am.J.Obst. & Gynec. 16 [Baltimore City Hospitals]; Knapp, Platt and Douglas, Septic Abortion (1960) 15 Obst. & Gynec. 344 [The New York Hospital]; Moritz & Thompson, Septic Abortion (1966) 95 Am.J.Obst. & Gynec. 46 [Miami Valley Hospital, Dayton, Ohio]; Stevenson & Yang, Septic Abortion With Shock (1962) 83 Am.J.Obst. & Gynec. 1229 [Detroit Receiving Hospital]; Studdiford & Douglas, Placental Bacteremia: A Significant Finding in Septic Abortion Accompanied by Vascular Collapse (1956) 71 Am.J. Obst. & Gynec. 842 [Bellevue Hospital, New York].)

10. One of the amici in support of respondent agrees: "There is a substantial risk that abortions performed by persons un-

[4] Although we may assume that the law was valid when first enacted, the validity of a law in 1850 does not resolve the issue of whether the law is constitutionally valid today. (Compare, e. g., Gray v. Sanders (1963) 372 U.S. 368, 381, 83 S.Ct. 801, 9 L.Ed.2d 821, with South v. Peters (1950) 339 U.S. 276, 277, 70 S.Ct. 641, 94 L.Ed. 834; Baker v. Carr (1962) 369 U.S. 186, 237, 82 S.Ct. 691, 7 L.Ed.2d 663, with Colegrove v. Green (1946) 328 U.S. 549, 556, 66 S.Ct. 1198, 90 L.Ed. 1432; Brown v. Board of Education (1954) 347 U.S. 483, 495, 74 S.Ct. 686, 98 L.Ed. 873; with Plessy v. Ferguson (1896) 163 U.S. 537, 550–551, 16 S.Ct. 1138, 41 L.Ed. 256.)

Constitutional concepts are not static. Our United States Supreme Court said, regarding the equal protection clause of the Fourteenth Amendment: "We agree, of course, with Mr. Justice Holmes that the Due Process Clause of the Fourteenth Amendment 'does not enact Mr. Herbert Spencer's Social Statics.' [Citation.] Likewise, the Equal Protection Clause is not shackled to the political theory of a particular era. In determining what lines are unconstitutionally discriminatory, we have never been confined to historic notions of equality, any more than we have restricted due process to a fixed catalogue of what was at a given time deemed to be authorized to practice surgery, carried out the limits of fundamental rights. * * *." (Harper v. Virginia State Bd. of Elections (1966) 383 U.S. 663, 669, 86 S.Ct. 1079, 1082, 16 L.Ed.2d 169; see also, Perez v. Sharp, *supra*, 32 Cal.2d 711, 727, 198 P.2d 17; Galyon v. Municipal Court, 229 Cal. App.2d 667, 671–672, 40 Cal.Rptr. 446, and cases cited therein ["[A] statute valid when enacted may become invalid by change in the conditions to which it is applied."]. See also, Means, *supra*, 14 N.Y.L.F. 411, 514–515.)

In the light of modern medical surgical practice, the great and direct infringement of constitutional rights which would result from a definition requiring certainty of death may not be justified on the basis of considerations of the woman's health where, as here, abortion is sought during the first trimester.

It is next urged that the state has a compelling interest in the protection of the embryo and fetus[11] and that such interest warrants the limitation on the woman's constitutional rights. Reliance is placed upon several statutes and court rules which assertedly show that the embryo or fetus is equivalent to a born child. However, all of the statutes and rules relied upon require a live birth or reflect the interest of the parents.[12]

in unregulated places, will bring injury or even death to the mother."

Authorities recognizing and discussing the tragic health problem created by illegal abortions are legion. (See, e. g., Bates, The Abortion Mill: An Institutional Study (1954) 45 J.Crim.L.C. & P.S. 157; Eastman, Expectant Motherhood (3d ed.1957) 106 et seq.; Gold, Erhardt, Jacobziner & Nelson, Therapeutic Abortions in New York City: A 20-Year Review (1965) 55 Am.J.Pub.Health 964, 970–971; Guttmacher (ed.1967) The Case for Legalized Abortion Now; Lader (1966) Abortion; Leavy & Kummer, Criminal Abortion: Human Hardship and Unyielding Laws (1962) 35 So.Cal.L.Rev. 123; Lucas, Federal Constitutional Limitations on the Enforcement and Administration of State Abortion Statutes (1968) 46 N.C.L.Rev. 730; Niswander, Medical Abortion Practices in the United States (1965) 17 W.Res.L.Rev. 403.)

11. It has been pointed out that "embryo" is more accurately descriptive than "fetus" in the instant case. Webster's New International Dictionary, *supra*, states: "* * * In mammals * * * *embryo* is applied only to early stages passed within the mother's body; later (in human embryology, usually after the third month of development) the young is called a *fetus*. * * *" (Italics in original.)

12. Statutes classifying the unborn child as the same as the born child require that the child be born alive for the provisions to apply. (E.g., Civ.Code, § 29 ["A child conceived, but not yet born, is to be deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth; * * *"]; Prob.Code, § 250 ["A posthumous child

In any event, there are major and decisive areas where the embryo and fetus are not treated as equivalent to the born child. Probably the most important is reflected by the statute before us. The intentional destruction of the born child is murder or manslaughter. The intentional destruction of the embryo or fetus is never treated as murder, and only rarely as manslaughter but rather as the lesser offense of abortion. (Perkins, Criminal Law, *supra*, p. 103; Means, *supra*, 14 N.Y.L.F. at p. 445.)[13]

Furthermore, the law has always recognized that the pregnant woman's right to life takes precedence over any interest the state may have in the unborn. The California abortion statutes, as to the abortion laws of all 51 United States jurisdictions, make an exception in favor of the life of the prospective mother. (See Stern, Abortion: Reform and the Law, *supra*, 59 J. Crim.L.C. & P.S. 84, 86–87; George, Current Abortion Laws: Proposals & Movements for Reform (1965) 17 W.Res.L.Rev. 366, 375.) Although there may be doubts as to whether the state's interest may ever justify requiring a woman to risk death, it is clear that the state could not forbid a woman to procure an abortion where, to a medical certainty, the result of childbirth would be death. We are also satisfied that the state may not require that degree of risk involved in respondent's definition, which would prohibit an abortion, where death from childbirth although not medically certain, would be substantially certain or more likely than not. Accordingly, the definition of the statute suggested by respondent must be rejected as an invalid infringement upon the woman's constitutional rights.

is considered as living at the death of the parent."]; Prob.Code, § 255 [An illegitimate child is the heir of his mother, "whether born or conceived."].)

Similarly, cases holding that a child can recover for injuries caused before his birth require that the child be born alive. The interest protected is that of the child; and the right attaches, not to the embryo or fetus, but to the living child. (Scott v. McPheeters, 33 Cal.App.2d 629, 637, 92 P.2d 678, 93 P.2d 562 [child injured at birth can bring action for injuries]; see also, Carroll v. Skloff (1964), 415 Pa. 47, 202 A.2d 9, 11; Tomlin v. Laws (1922) 301 Ill. 616, 134 N.E. 24, 25; Prosser, Law of Torts (3d ed.1964) at p. 356 ["The child, provided that he is born alive, is permitted to maintain an action * * *."].)

Where the embryo or fetus is allowed to assert rights before birth it is the prospective mother or parents who are bringing the action; thus it is their interest that the law protects. (Kyne v. Kyne, 38 Cal.App.2d 122, 127–128, 100 P.2d 806 [action on behalf of unborn child for support and to establish paternity]; People v. Sianes, 134 Cal.App. 355, 357–358, 25 P.2d 487 [criminal action for nonsupport against father of unborn child]; People v. Yates, 114 Cal. App.Supp. 782, 788, 298 P. 961 [same].) Similarly, in those jurisdictions which recognize a cause of action for the loss of an unborn child, it is the parents' "distressing wrong in the loss of a child" that the law has recognized. (Prosser, *supra*, § 56, at p. 357; Torigian v. Watertown News Co. Inc. (1967) 352 Mass. 446, 448, 225 N.E.2d 926.)

In a case involving a pregnant woman who refused a blood transfusion, in ordering the transfusion the court made clear that it was concerned with the woman, rather than the fetus: "* * * Mrs. Jones wanted to live." (Application of President & Directors of Georgetown Col. (1964) 118 U.S.App.D.C. 90, 331 F.2d 1000, 1009, cert. denied, 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746, but see Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson (1964) 42 N.J. 421, 201 A.2d 537, 538, cert. denied, 377 U.S. 985, 84 S.Ct. 1894, 12 L.Ed.2d 1032, suggesting that an 8-month pregnant woman could be required to have blood transfusions to protect the unborn child.)

Although sections 3705 and 3706 of the Penal Code, which provide for suspending the execution of a pregnant woman, reflect an interest in the unborn child, the sections do not affect any other significant private interests and thus furnish no basis to evaluate the interest protected or to conclude that the embryo or fetus is equivalent to a born child.

13. One case has held that, for purposes of the manslaughter and murder statutes, human life may exist where childbirth has commenced but has not been fully completed. (People v. Chavez, 77 Cal.App.2d 621, 624, 626, 176 P.2d 92.)

Another definition of the term "necessary to preserve" is suggested by People v. Abarbanel, *supra*, 239 Cal.App.2d 31, 32, 34, 48 Cal.Rptr. 336, where the court held that an abortion was not unlawful where the obstetrician performed the abortion based on the "possibility" of suicide. *Abarbanel* might be understood as meaning that "necessary to preserve" refers to a possibility of death different from or greater than the ordinary risk of childbirth. To so interpret "necessary to preserve" would mean that in nearly every case, if not all, a woman who wished an abortion could have one. A woman who is denied a desired lawful abortion and forced to continue an unwanted pregnancy would seem to face a greater risk of death, because of psychological factors, than the average woman, because the average includes all those women who wish to bear the child to term. The psychological factor alone, which under *Abarbanel* is a proper consideration, would seem to be decisive. Such a construction of the statute permitting voluntary abortions would render the statute virtually meaningless. Moreover, to determine the right to an abortion solely on the basis of the dangers of childbirth without regard to the relative dangers of the abortion would be contrary to good medical practice.

Nor can the statute be made certain by reading it as "substantially or reasonably" necessary to preserve the life of the mother. In the present context those terms are not sufficiently precise and would be subject to such different interpretations as to add little or nothing to "necessary." Thus, many people may feel that an abortion is reasonably or substantially necessary to preserve life where the risk of death is double or triple the ordinary risk in childbirth. Others may believe that anything which increases the possibility of death is a substantial risk which is not to be undertaken in the absence of countervailing considerations, so that "reasonably necessary" or "substantially necessary" becomes as destructive of the statute as "possibility of death." On the other hand, there may be those who feel that there is no reasonable or substantial necessity until it is more likely than not that the pregnant woman will not survive childbirth. Although in other contexts the implication of words such as "reasonably" and "substantially" may add certainty and avoid other due process objections, in the instant situation the implication of such words would merely increase the uncertainty.

There is one suggested test which is based on a policy underlying the statute and which would serve to make the statute certain. The test is probably in accord with the legislative intent at the time the statute was adopted. The Legislature may have intended in adopting the statute that abortion was permitted when the risk of death due to the abortion was less than the risk of death in childbirth and that otherwise abortion should be denied. As we have seen, at the time of the adoption of the statute abortion was a highly dangerous procedure, and under the relative safety test abortion would be permissible only where childbirth would be even more dangerous. In light of the test and the then existing medical practice, the question whether abortion should be limited to protect the embryo or fetus may have been immaterial because any such interest would be effectuated by limiting abortions to the rare cases where they were safer than childbirth.

The suggested test would involve an application of medical principles. Medical science may be able to tell us the proper method to treat a patient to minimize the risk of death, but without resort to matters outside medical competence, it cannot tell us the circumstances in which the safest treatment should be rejected and a more dangerous treatment followed in order to protect an embryo or fetus.

The new Therapeutic Abortion Act (Health & Saf.Code, §§ 25950–25954), has adopted a test analogous to the suggested one. Under the new statute, abortion is permissible during the first 20 weeks of pregnancy by a licensed physician in an accredited hospital (Health & Saf.Code, §§

25951, 25953) if it is determined under prescribed procedures either that "There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother" (Health & Saf.Code, § 25951, subd. (c) (1)), or that "The pregnancy resulted from rape or incest." (Health and Saf.Code, § 25951, subd. (c) (2).) Mental health includes mental illness to the extent that the woman would be dangerous to herself. (Health & Saf.Code, § 25954.) By limiting the abortion to the first 20 weeks, the Legislature has taken into account the danger to the mother of the later abortion and, by requiring the abortion to be performed by a licensed physician in an accredited hospital, has recognized the danger to the mother of other procedures. The further criteria for determining whether an abortion is permissible is the pregnant woman's physical and mental health. Thus, the test established is a medical one, whether the pregnant woman's physical and mental health will be furthered by abortion or by bearing the child to term, and the assessment does not involve considerations beyond medical competence. There is nothing to indicate that in adopting the Therapeutic Abortion Act the Legislature was asserting an interest in the embryo.

Although the suggested construction of former section 274, making abortion lawful where it is safer than childbirth and unlawful where abortion is more dangerous, may have been in accord with legislative intent, the statute may not be upheld against a claim of vagueness on the basis of such a construction. The language of the statute, "unless the same is necessary to preserve her life," does not suggest a relative safety test, and no case interpreting the statute has suggested that the statute be so construed. None of the parties or numerous amici who have filed briefs in the instant case suggest that the statute applies a relative safety test; to the contrary, the position of the parties and amici, including numerous lawyers, doctors, educators, clergymen and laymen, implies that the statute does not apply that standard. Thus, those claiming the statute is invalid urge that the only valid standard would be a relative safety test and that the statute fails to adopt such a test, and those urging the validity of the statute either state or imply that the standard applied is more restrictive. In the circumstances, we are satisfied that the statute may not be construed to adopt the relative safety test as against a claim of vagueness, because the language does not suggest that test and because of the practical evidence before us that men of "common" intelligence, indeed of uncommon intelligence, have not guessed at this meaning.[14]

14. The practical aspects of the need to guess at the meaning of the abortion statute is shown by Packer & Gampell, Therapeutic Abortion: A Problem in Law and Medicine (1959) 11 Stan.L.Rev. 417. A questionnaire survey directed to 29 San Francisco Bay Area and Los Angeles hospitals (*id.*, at p. 423) based on hypothetical cases involving pregnant women seeking abortions yielded the following results (*id.*, at p. 444):

Case No.	Authors' Evaluation of Legality of Abortion	Hospital Would Perform Abortion	
		Yes	No
1	Yes	21	1
2	No	10	12
3	No	6	16
4	No	15	7
5	No	8	13
6	No	8	14
7	Yes	17	4
8	No	5	17
9	Prob. Yes	10	11
10	Maybe	17	4
11	No	1	20

[5] The problem caused by the vagueness of the statute is accentuated because under the statute the doctor is, in effect, delegated the duty to determine whether a pregnant woman has the right to an abortion and the physician acts at his peril if he determines that the woman is entitled to an abortion. He is subject to prosecution for a felony and to deprivation of his right to practice medicine (Bus. & Prof.Code, § 2377) if his decision is wrong. Rather than being impartial, the physician has a "direct, personal, substantial, pecuniary interest in reaching a conclusion" that the woman should not have an abortion. The delegation of decision-making power to a directly involved individual violates the Fourteenth Amendment. (Tumey v. Ohio (1927) 273 U.S. 510, 523, 47 S.Ct. 437, 71 L.Ed. 749; see also State Board of Dry Cleaners v. Thrift-D-Lux Cleaners, 40 Cal.2d 436, 448, 254 P.2d 29 ["[T]he statute assumes to confer legislative authority upon those who are directly interested in the operation of the regulatory rule * * *."]; Blumenthal v. Board of Medical Examiners, 57 Cal.2d 228, 235, 18 Cal.Rptr. 501, 504, 368 P.2d 101, 104.)

The inevitable effect of such delegation may be to deprive a woman of an abortion when under any definition of section 274 of the Penal Code, she would be entitled to such an operation, because the state, in delegating the power to decide when an abortion is necessary, has skewed the penalties in one direction: *no* criminal penalties are imposed where the doctor refuses to perform a necessary operation, even if the woman should in fact die because the operation was not performed.

The pressures on a physician to decide not to perform an absolutely necessary abortion are, under section 274 of the Penal Code, enormous, and because section 274 authorizes—and requires—the doctor to decide, at his peril, whether an abortion is necessary, a woman whose life is at stake may be as effectively condemned to death as if the law flatly prohibited all abortions.

To some extent the Therapeutic Abortion Act reduces these pressures. The act specifically authorizes an abortion by a licensed physician in an accredited hospital where the abortion is approved in advance by a committee of the medical staff of the hospital, applying medical standards. (Health & Saf.Code, § 25951.) At least in cases where there has been adherence to the procedural requirements of the statute, physicians may not be held criminally responsible, and a jury may not subsequently determine that the abortion was not authorized by statute.

[6] We conclude that the validity of section 274 of the Penal Code before amendment cannot be sustained.[15]

Since section 274 is invalid, Dr. Belous' conviction for violation of section 182 of the Penal Code, conspiracy to commit abortion, must likewise fall. The judgment is reversed with directions to the trial court to dismiss the indictment.

TRAYNOR, C. J., TOBRINER, J., and PIERCE,* J. pro tem., concur.

BURKE, Justice (dissenting).
I dissent.

The defendant was found guilty by jury trial of a wilful violation of the abortion statute as it existed at the time of the offense. That he violated the statute is all but conceded in the briefs filed in his behalf. Although he testified that he directed the young couple to a doctor, unlicensed in California, because he believed that if they

15. It has been urged that the Therapeutic Abortion Act is unconstitutional because it contains uncertainties similar to those in the repealed statute, because it infringes on the woman's right to choose whether to bear children, and because the act does not expressly permit an abortion where there is a likelihood that a deformed child will be born. Since the act was adopted after the abortion in the instant case, we do not reach the issue of its validity.

* Assigned by the Chairman of the Judicial Council.

carried out their threats of going to Tijuana to procure an abortion the young woman's life would be in danger, he acknowledged upon cross-examination that her life would not have been endangered if she were not aborted. His assertions that he acted in good faith and out of compassion are tainted somewhat by the evidence which showed that he had referred other women to the same unlicensed physician on a number of occasions and that he had participated on at least one-half of those occasions in the fee paid the abortionist.

Had the doctor truly believed that the young woman's life was in danger he could have done what was the common practice of taking the patient to one of the several hospitals in which therapeutic abortions were being performed. To my knowledge there is not one single instance of a decision of the appellate courts of this state in which a doctor or a hospital has been prosecuted for the performance of an abortion where an independent hospital committee deemed the abortion to be necessary to preserve the woman's life. The plain fact is, as the jury found it to be, that this doctor, whatever his motive, possessed the intent to assist in procuring the miscarriage of the woman for reasons other than to preserve her life. This is the specific intent which the law requires for conviction.

He supplied to the jury the answer an independent hospital committee undoubtedly would have given him had he seen fit to seek its approval for an abortion—the patient could bear the child without endangering her life; therefore, to abort her would violate the law.

The threatened danger to the woman's life arose only from the couple's assertions that they would seek an illegal abortion by an unlicensed person. To assist them in attaining this goal was to flaunt his profession's own standards and to aid in bringing about a direct violation of the law.

The majority would reverse the conviction by declaring the statute unconstitutional because of asserted uncertainty in the phrase, "necessary to preserve [the woman's] life."[1] This phrase has been an integral part of the California law against illegal abortions from the time of its enactment in 1872 until the 1967 amendment to the section, and similar language was in the original statute adopted in 1850.[2] Thus for over a hundred years in this state doctors, hospital committees, judges, lawyers and juries have been called upon to give the phrase the common sense interpretation which the words appear to me to suggest. For this court over a hundred years later to find the language unconstitutionally vague and uncertain is a "negation of experience and common sense." (United States v. Ragen, 314 U.S. 513, 524, 62 S.Ct. 374, 379, 86 L.Ed. 383.)

Not only was the phrase long used in the California statute, it was also employed at common law (see, e. g., Perkins on Criminal Law (2d ed.) p. 145; Clark and Marshall, Crimes 6th ed.) pp. 688-689) and is or has been in the abortion statutes of many states (see, e. g., Am.Jur.2d, Abortion, § 9, p. 192; 153 A.L.R. 1218, 1266; Smith, Abortion and the Law (1967) p. 7). Implicit in the decisions of this court, as well as those of countless other courts, is the view that the phrase does not render such a statute invalid (see, e. g., People v. Davis, 43 Cal.2d 661, 276 P.2d 801; People v. Gallardo, 41 Cal.2d 57, 257 P.2d 29; People v. Powell, 34 Cal.2d 196, 208 P.2d 974; Peo-

1. Section 274 then read: "Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is *necessary to preserve her life*, is punishable * * *." (Italics added.)

2. The 1850 statute (ch. 99, § 45, p. 233) provided that every person who did any of the enumerated acts with a specified intent shall be punishable "*Provided*, that no physician shall be affected * * * who, in the discharge of his professional duties, deems it necessary to produce the miscarriage of any woman in order to save her life."

ple v. Wilson, 25 Cal.2d 341, 153 P.2d 720; People v. Rankin, 10 Cal.2d 198, 74 P.2d 71). In State v. Moretti, 52 N.J. 182, 244 A.2d 499, 504 [cert. den. 393 U.S. 952, 89 S.Ct. 376, 21 L.Ed.2d 363] the court stated that when the phrase "lawful justification," as used in a statute prohibiting abortions done maliciously or without lawful justification, is confined "to the preservation of the mother's life," the statute is not subject to constitutional attack on the ground of vagueness. (See also State v. Elliott, 234 Or. 522, 383 P.2d 382, 384–385.)

The proper test as to certainty was stated by this court in People v. Howard, 70 A.C. 659, 665, 75 Cal.Rptr. 761, 764, 451 P.2d 401, 404, to be: "'A statute should be sufficiently certain so that a person may know what is prohibited thereby and what may be done without violating its provisions, but it cannot be held void for uncertainty if any reasonable and practical construction can be given to its language. As stated in Pacific Coast Dairy v. Police Court, 214 Cal. 668, at page 676, 8 P.2d 140, 143, 80 A.L.R. 1217, "Mere difficulty in ascertaining its meaning, or the fact that it is susceptible of different interpretations will not render it nugatory. Doubts as to its construction will not justify us in disregarding it." [Citation.]'"

The meaning of the phrase "necessary to preserve [the woman's] life" was considered in People v. Ballard, 167 Cal.App.2d 803, 814–815, 335 P.2d 204, 212, wherein the court stated, "Surely, the abortion statute (Pen.Code, § 274) does not mean by [this phrase] that the peril to life be imminent. It ought to be enough that the dangerous condition 'be potentially present, even though its full development might be delayed to a greater or less extent. Nor was it essential that the doctor should believe that the death of the patient would be otherwise *certain* in order to justify him in affording present relief.' (State v. Dunklebarger, 206 Iowa 971, 221 N.W. 592, 596; see also Rex v. Bourne, 1 K.B. 687 * * *; Commonwealth v. Wheeler, 315 Mass. 394, 53 N.E.2d 4; 23 So. Cal.L.Rev. 523.) In State v. Powers * * 155 Wash. 63, 67, 283 P. 439, 440, the court satisfied itself with an interpretation of 'necessity to save life' by stating, '*If the appellant in performing the operation did something which was recognized and approved by those reasonably skilled in his profession practicing in the same community * * * then it cannot be said that the operation was not necessary to preserve the life of the patient.*'" (Italics added.) (See also People v. Abarbanel, 239 Cal.App. 2d 31, 34, 48 Cal.Rptr. 336; People v. Ballard, 218 Cal.App.2d 295, 307, 32 Cal.Rptr. 233.)

Amici for appellant, 178 deans of medical schools, state that the italicized sentence quoted from People v. Ballard, *supra*, 167 Cal.App.2d 803, 814–815, 335 P.2d 204, is in error because "the medical profession has 'approved' abortions in cases [in which the objective was not to preserve the life of the woman and therefore] clearly outside of Penal Code section 274. Packer & Gampell, Therapeutic Abortion: A Problem in Law and Medicine, 11 Stan.L.Rev. 417, 447. * * *" However, that sentence must be understood to mean recognized and approved by such persons as being required to preserve the life of the patient.

The word "preserve" is defined in the dictionary as "1. To keep or save from injury or destruction; * * * to protect; save. 2. To keep in existence or intact; * * * To save from decomposition * *." (See Webster's New Internat. Dict. (3d ed. 1961).) As used in section 274, the word "preserve" has been regarded as synonymous with "save" (see, e. g., People v. Kutz, 187 Cal.App.2d 431, 436, 9 Cal.Rptr. 626; People v. Malone, 82 Cal.App.2d 54, 59, 185 P.2d 870; Stern v. Superior Court, 78 Cal.App.2d 9, 18, 177 P.2d 308), and to save a life ordinarily is understood as meaning to save from destruction, i. e. dying—not merely from injury. Thus the precipitation of a psychosis in the absence of a genuine threat of suicide is not a threat to life under section 274. (See Packer and Gampell, Therapeutic Abortion: A

Problem in Law and Medicine, 11 Stan. L.Rev. 417, 433, 436.)

That the Legislature used the word "preserve" in the sense of save from destruction also appears from the purpose of the section. The law historically in various contexts has regarded the unborn child as a human being. (See Louisell, Abortion, The Practice of Medicine, and the Due Process of Law, 16 U.C.L.A. L.Rev. 233, 234–244.) Louisell (at p. 244) quotes from Prosser on Torts (3d ed. 1964) that "[M]edical authority has recognized long since that the child is in existence from the moment of conception, and for many purposes its existence is recognized by the law. The criminal law regards it as a separate entity, and the law of property considers it in being for all purposes which are to its benefit, such as taking by will or descent. * * * All writers who have discussed the problem have joined * * in maintaining that the unborn child in the path of an automobile is as much a person in the street as the mother." In Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, 538 [cert. den. 377 U.S. 985, 84 S.Ct. 1894, 12 L.Ed.2d 1032] it was held that an unborn child of a woman who did not wish blood transfusions because they were contrary to her religious convictions was entitled to the law's protection and that an order would be made to insure such transfusions to the mother in the event they are necessary in the opinion of the attending physician.

Several statutes show that the California law has been in accord in regarding the unborn child as a human being for various purposes. (See, e. g., Pen.Code, §§ 3706 and 270; Civ.Code, § 29.)[3] In Scott v. McPheeters, 33 Cal.App.2d 629, 634, 92 P.2d 678, 681, the court declared: "The respondent asserts that the provisions of section 29 of the Civil Code are based on a fiction of law to the effect that an unborn child is a human being separate and distinct from its mother. We think that assumption of our statute is not a fiction, but upon the contrary that it is an established and recognized fact by science and by everyone of understanding."

It is reasonable to believe that section 274, as it read at the time in question, was not an exception to the law's attitude respecting the unborn child as a human being and that it was designed to protect not only the mother's life but also that of the child. In view of that purpose it would appear that the Legislature intended that the child would be deprived of his right to life only if in the absence of an abortion there was a danger of the mother's death—not merely of injury to her.

"'[T]he Constitution does not require impossible standards'; all that is required is that the language 'conveys sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices * * *.' United States v. Petrillo, 332 U.S. 1, 7–8, 67 S.Ct. 1538, 91 L.Ed. 1877." (Roth v. United States, 354 U.S. 476, 491, 77 S.Ct. 1304, 1312, 1 L.Ed.2d 1498.) The phrase in question, when applied according to the standard heretofore stated (namely, whether persons reasonably skilled in their profession practicing in the same community recognized and approved the act as being required to save the patient from dying) clearly gives such warning.

Furthermore, section 274 punishes only those who act with "'* * * the intent to commit a criminal abortion, that is, an abortion for a purpose other than to preserve [i. e. save from destruction] the life of the mother.'" (People v. Abar-

3. Penal Code section 3706 requires that the execution of a death penalty be suspended if the defendant is pregnant and without regard to the stage of pregnancy.
Penal Code section 270 makes punishable a father's wilful failure to provide a minor child with necessary items and provides that "A child conceived but not yet born is to be deemed an existing person in so far as this section is concerned."
Civil Code section 29 provides in part that "A child conceived, but not yet born, is to be deemed an existing person, so far as may be necessary for its interests in the event of its subsequent birth * * *."

banel, *supra*, 239 Cal.App.2d 31, 34–35, 48 Cal.Rptr. 336, 339; People v. Ballard, *supra*, 167 Cal.App.2d 803, 817, 335 P.2d 204.) The requirement of such an intent eviscerates much of the majority's claim that the section is impermissibly vague. (See generally Mishkin v. New York, 383 U.S. 502, 507, fn. 5, 86 S.Ct. 958, 16 L.Ed.2d 56; Boyce Motor Lines, Inc. v. United States, 342 U.S. 337, 342, 72 S.Ct. 329, 96 L.Ed. 367.) A person who performs an abortion with such an intent has fair warning that his conduct may violate the law even though he may not be certain where the jury will draw the line on the matter of necessity.

The principal cases relied upon by the majority, in which statutes have been declared unconstitutionally vague, do not support such a finding when applied to the abortion statute. In People v. McCaughan, 49 Cal.2d 409, 317 P.2d 974, the statute prohibited, among other conduct, "harsh" or "unkind" treatment of a mentally ill person. These words were held not to have an established meaning either at common law or as a result of adjudication. They were held unconstitutionally vague. On the other hand, the phrase "neglect of duty" and the word "cruel" were upheld because they did have such well established meanings, just as do the words utilized in the phrase under attack here.

Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 83 L.Ed. 888, construed a statute defining "gangster" and making it a crime for anyone to be such a person. The phrase "consisting of two or more persons" was all that purported to define "gang," and the word "gang" was held so vague and uncertain as to violate the Fourteenth Amendment.

Connally v. General Const. Co., 269 U.S. 385, 395, 46 S.Ct. 126, 128, 129, 70 L.Ed. 322, involved a statute requiring a contractor to pay his employees "not less than the *current rate of* * * * *wages* in the *locality* where the work is performed," and the court held the italicized words unconstitutionally vague. Unlike the statute involved here, the statute in question was a new statute and the court noted that its application "depends, not upon a word of fixed meaning in itself, or one made definite by statutory or judicial definition * * *."

In contrast to these cases, here the challenged statute has a fixed meaning, frequently applied and impliedly interpreted by the courts in the more than one hundred years of its existence. In addition, the statute requires proof of the specific intent to commit a criminal abortion before a person may be successfully prosecuted under it.

There is, of course, a presumption in favor of constitutionality, and the invalidity of a legislative act must be clear before it can be declared unconstitutional. (In re Anderson, 69 Cal.2d 613, 628, 73 Cal.Rptr. 21, 447 P.2d 117.)

The majority cite no authority holding that the term "necessary to preserve [the woman's] life" is impermissibly vague, and I agree with the conclusion as to the constitutionality of the section that is implicit in the multitude of past decisions affirming convictions for illegal abortion, and for murder where death was the result of such an act.

I would affirm the judgment.

McCOMB and SULLIVAN, JJ., concur.

SULLIVAN, Justice (dissenting).

I concur in the views of Justice BURKE. Reading the majority's attack on Penal Code section 274, one would think that the English language which has been the sensitive instrument of our system of law for over 500 years, has lost, by the mere passage of time, all capacity for clarity of expression. The majority strike down the statute solely because they find so vague and uncertain as to offend constitutional standards of due process, a single brief clause of nine words of long and common usage: "unless the same is necessary to preserve her life." There is no mystique enveloping the statute and, as Justice BURKE points

out, the clause now challenged has stood the test of over a hundred years, and presumably of countless human incidents falling within its scope, apparently without evoking a single whimpering cry against it.

The mandate of the section is plain and clear, and simply means this: no one shall intentionally procure the miscarriage of a woman unless it is necessary to save her life. "The criminal intent necessary to support a conviction of illegal abortion must show that it was performed for a purpose other than to save [the abortee's] life." (People v. Abarbanel (1965) 239 Cal.App. 2d 31, 34, 48 Cal.Rptr. 336, 338.) I dare say that the average man in the street, confronted with this law, would have little trouble in extracting its sense (we hold him accountable to much more complicated enactments); and the doctor, with his professional training and expertise would have even less. We have said that "[i]t is a cardinal rule, to be applied to the interpretation of particular words, phrases, or clauses in a statute or a Constitution, that the entire substance of the instrument or of that portion thereof which has relation to the subject under review should be looked to in order to determine the scope and purpose of the particular provision therein of which such words, phrases, or clauses form a part, and in order also to determine the particular intent of the framers of the instrument in that portion thereof wherein such words, phrases, or clauses appear." (Wallace v. Payne (1925) 197 Cal. 539, 544, 241 P. 879, 881). In the case before us, the challenged clause when so examined, is clear in meaning.

Yet the majority, by engaging in a process of elaborate and lavish analysis, transform that which is simple and lucid into something complex and arcane. Actually the analysis is focused on only three words: "necessary to preserve." Their fair equivalent is "necessary to save" (see People v. Abarbanel, *supra*, 239 Cal.App.2d 31, 34, 48 Cal.Rptr. 336; People v. Ballard (1959) 167 Cal.App.2d 803, 814, 817, 335 P.2d 204). Rather than evaluate these words in the light of "the entire substance" (see Wallace v. Payne, *supra*, 197 Cal. 539, 544, 241 P. 879), the majority resort to a dissection: "There is, of course, no standard definition of 'necessary to preserve,' and taking the words separately, no clear meaning emerges." (Majority opn., p. 358.) In support of this thesis, it is asserted that the word "necessary" does not have a "fixed meaning." In general, few words do.[1] It is futher insisted that the definition of "preserve" is "even less enlightening." Accordingly, the majority discard its obvious meaning, that is, "save," as used in the context "to save a life." From such analysis, the opinion concludes "that the term 'necessary to preserve' in section 274 of the Penal Code is not susceptible of a construction that does not violate legislative intent and that is sufficiently certain to satisfy due process requirements without

1. "Words, however, do not have absolute and constant referents. 'A word is a symbol of thought but has no arbitrary and fixed meaning like a symbol of algebra or chemistry, * * *.' (Pearson v. State Social Welfare Board (1960) 54 Cal.2d 184, 195, 5 Cal.Rptr. 553, 559, 353 P.2d 33, 39.) The meaning of particular words or groups of words varies with the '* * * verbal context and surrounding circumstances and purposes in view of the linguistic education and experience of their users and their hearers or readers (not excluding judges). * * * A word has no meaning apart from these factors; much less does it have an objective meaning, one true meaning.' (Corbin, The Interpretation of Words and the Parole Evidence Rule (1965) 50 Cornell L.Q. 161, 187.)" (Pacific Gas & E. Co. v. G. W. Thomas Drayage Etc. Co. (1968) 69 Cal.2d 33, 38, 69 Cal.Rptr. 561, 564, 442 P.2d 641, 644.)

"Words are used in an endless variety of contexts. Their meaning is not subsequently attached to them by the reader but is formulated by the writer and can only be found by interpretation in the light of all the circumstances that reveal the sense in which the writer used the words." (Universal Sales Corp. v. Cal. etc. Mfg. Co. (1942) 20 Cal.2d 751, 776, 128 P.2d 665, 679, Traynor, J. concurring.)

improperly infringing on fundamental constitutional rights." (Majority opn., p. 357) Actually the gist of this is that the three words "necessary to preserve" are so shrouded in darkness that the average man cannot detect what they mean although average men and men above average have had no trouble with them for a hundred years.

I cannot accept so tortured a conclusion, wrenched from a statute which has had its roots in the law's historic solicitude for the priceless gift of life. The statute plainly prohibits an abortion unless it is necessary to save the mother's life. It strains reason to say that this crystal-clear exception to the law is "so vague that men of common intelligence must necessarily guess at its meaning * * *." (Lanzetta v. New Jersey (1939) 306 U.S. 451, 453, 59 S.Ct. 618, 619, 83 L.Ed. 888—see majority opn., p. 357.) And it strains credulity to assume that this defendant, who under the evidence wilfully violated the statute, had to engage in any such guesswork with respect to the law governing his conduct.

I would affirm the judgment.

McCOMB, J., concurs.

Rehearing denied; McCOMB, BURKE and SULLIVAN, JJ., dissenting.

PIERCE, J., sitting pro tem. in place of MOSK, J., who deemed himself disqualified.



STATE of Kansas, Appellee,

v.

Austin Lyrrell JAMIESON, Appellant.

No. 45800.

Supreme Court of Kansas.

Jan. 23, 1971.

Defendant was convicted of procuring an abortion. The Johnson District Court, Division No. 1, Herbert W. Walton, J., rendered judgment, and defendant appealed. The Supreme Court, Hatcher, C., held that information attempting to charge abortion was fatally defective for failure to negative exception of abortion statute providing that "unless the same shall have been necessary to preserve the life of such woman."

Defendant discharged from judgment and sentenced.

1. Indictment and Information ⇐111(1)

Since there is exception in abortion statute providing that statute will not apply if abortion is necessary to preserve life of woman, information charging abortion must negative exception in order to charge offense. K.S.A. 21-437.

2. Indictment and Information ⇐99

If allegations of information may be true, and defendant still is innocent of of-

fense defined by statute on which information is based, information is jurisdictionally defective.

3. Abortion ⇐2

Manner of performance of abortion may be unlawful and still not constitute offense under abortion statute, if abortion is necessary to save life of mother. K.S.A. 21–437.

4. Indictment and Information ⇐111(1)

Information attempting to charge abortion was fatally defective for failure to negative exception of abortion statute providing that "unless the same shall have been necessary to preserve the life of such woman." K.S.A. 21–437.

Syllabus by the Court

1. Where there is an exception in a statute defining abortion, and the exception forms an integral part of the offense defined, the information must negative the exception in order to charge the offense.

2. A governing rule is that if the allegations of an information may be true and the defendant still be innocent of the offense defined by the statute the information is jurisdictionally defective.

3. An information attempting to charge the offense of abortion as defined by K.S.A. 21–437 is examined and found to be fatally defective for failure to negative the exception—"unless the same shall have been necessary to preserve the life of such woman."

Roy Lucas, New York City, argued the cause, and James C. Thompson and Anthony R. Russo, Kansas City, were with him on the brief for appellant.

David Zook, Asst. County Atty., argued the cause, and Kent Frizzell, Atty. Gen., James W. Bouska, County Atty., and Mark L. Bennett, Jr., Asst. County Atty., were with him on the brief for appellee.

HATCHER, Commissioner.

This is an appeal from a verdict and judgment convicting the defendant of the offense of procuring an abortion contrary to the provisions of K.S.A. 21–437.

Defendant's motion for a new trial was overruled and he was sentenced to confinement in the Johnson County jail for one year. He has appealed.

Although the constitutionality of the Kansas Abortion Act is challenged, we need only to consider appellant's first contention which reads:

"The trial court erred in failing to grant defendant's motion to dismiss because the information under which defendant was charged was jurisdictionally defective in that it failed to negatively aver the statutory exception—that the act charged was not 'necessary to preserve the life of such woman'. Omission of an essential element of the offense renders appellant's conviction void for lack of jurisdiction over the subject matter."

We are inclined to agree with appellant's contention. The information, with formal parts omitted, states:

"I, Hugh H. Kreamer the undersigned, Assistant County Attorney of said County, in the name, and by the authority, and on behalf of the State of Kansas, come now here, and give the Court to understand and be informed that on or about the 15th day of June A.D., 1969, in said County of Johnson, and State of Kansas, one Austin Lyrrell Jamieson did then and there Unlawfully and willfully administer to Susan Thoms, a pregnant woman, certain substance and did use or employ certain instruments, commonly known as a catheter tube and others, the names of which are unknown, with the intent thereby to procure an abortion or miscarriage of said woman.

"Contrary to the form of the Statute in such case made and provided, and against the peace and dignity of the State of Kansas, as he is informed and verily believes."

The abortion act (K.S.A. 21-437) in effect at the time of the offense attempted to be charged reads:

"Every physician or other person who shall willfully administer to any pregnant woman any medicine, drug, or substance whatsoever, or shall use or employ any instrument or means whatsoever, with intent thereby to procure abortion or the miscarriage of any such woman, *unless the same shall have been necessary to preserve the life of such woman*, or shall have been advised by a physician to be necessary for that purpose, shall upon conviction be adjudged guilty of a misdemeanor, and punished by imprisonment in the county jail not exceeding one year, or by fine not exceeding five hundred dollars, or by both such fine and imprisonment." (Emphasis supplied.)

There have been numerous rules stated in an attempt to determine when an exception in a criminal statute must be stated in the information.

One of the earlier rules relied on by appellant placing emphasis on the location of the exception in the statute, was repudiated by this court in State v. Eary, 121 Kan. 339, 246 P. 989, where it is said:

"The rule that exceptions contained in the clause of a statute creating an offense must be negatived, was adopted by this court at a very early day, from Archbold's Criminal Pleading and Evidence, and regarded form rather than substance:

" 'The law on this point is plain and is well stated in Archbold's Criminal Practice and Pleading, page 118, as follows: "If there be any exception contained in the same clause of the act which creates the offense, the indictment must show negatively that the defendant or the subject of the indictment does not arise within the exception. If, however, the exception or proviso be in a subsequent clause or statute, or although in the same section, yet if it be not incorporated with the enacting clause by any words of reference, it is in that case matter of defense for the other party, and need not be negatived in the pleading." ' State of Kansas v. Thompson, 2 Kan. 432, 436 [1864].

"We now regard substance instead of form, and unless the exception, wherever found, inheres so integrally in the offense that liability would necessarily be precluded unless the exception were expressly negatived, it is a matter of defense. * * *" (P. 343, 246 P. p. 991.)

[1] The well established rule in all jurisdictions is that there must be negative averment of an exception where it constitutes an integral part of the offense defined in the statute.

In State v. Hill, 189 Kan. 403, at page 410, 369 P.2d 365, at page 370, 91 A.L.R.2d 750, we stated:

"* * * The office of an exception in a statute is well understood. It is intended to exempt something from the scope of the general words of a statute or to qualify or restrain the generality of the substantive enactment to which it is attached. The relative position of an exception is unimportant since the act must be construed as a whole. It may, as here, appear in a section by itself, and when that is done it has precisely the same meaning that it would have if the exception were appropriately incorporated in the other section. (50 Am.Jur., Statutes, § 431, p. 451.) *We conclude that 21-956 is not merely defensive as the state contends, but constitutes an integral part of the offense defined.* As thus construed, the burden rests upon the state to allege and prove that the articles sold or exposed to sale on Sunday were of the kind and character included in the statute's prohibition and were not those excepted." (Emphasis supplied.)

The general rule may be found in 1 C.J.S. Abortion § 21, p. 327:

"Following the rules applicable to indictments and informations generally, where there is an exception in the stat-

ute defining abortion, which exception forms a part of the description of the offense so that the ingredients thereof cannot be accurately stated if the exception is omitted, the indictment must negative the exception, otherwise the offense defined by the statute is not charged. This averment should be made in terms which are direct and certain, and it should not be set out parenthetically or in ambiguous terms."

[2] There may sometimes be a dispute as to just when an exception constitutes an integral part of the offense. In State v. Ferron, 122 Kan. 845, 253 P. 402, this court announced in a very concise rule for determining just when an exception is an integral part of the offense charged. We stated:

"* * * A governing rule is that if the allegations of the information may be true and the defendant still be innocent, the information is bad. * * *" (P. 847, 253 P. p. 403.)

The defendant in the present case might be found guilty of the abortion and still be innocent under the language of the statute creating the exception.

The appellee in its brief stresses the use of the word "unlawful," stating:

"* * * The information filed herein alleges that the acts performed were performed in an 'unlawful' manner, which although failing to recite all the details, which utmost certainty might require, still fully apprised the defendant of the crime with which he was charged. * * *"

[3] The manner of the performance of the abortion might be unlawful and still not constitute an offense under the statute if necessary to save the life of the mother. It was stated in State v. Bridges, (Mo.) 412 S.W.2d 455, at page 458:

"* * * It does not follow, however, from the fact that the abortion was unlawful and felonious that the abortion was not necessary to save the mother's life. The necessity might exist and the act yet be unlawful and felonious by reason of the manner in which the defendant performed the act. A charge that the act was done unlawfully and feloniously does not supply the missing required allegation that the abortion was not necessary to preserve her life."

It might also be noted here that the appellee cites cases dealing with the burden of proof. We make no comment other than to say that we are now dealing with the allegations of an information.

The appellee also relies on the case of State v. Perello, 102 Kan. 695, 171 P. 630, where this court held that an exception in the intoxicating liquor law need not be stated in the information. In the *Perello* case this court went to considerable pains to state why the case was an exception to the general rule. It stated at page 697 of the opinion, at page 631 of 171 P.:

"The statute we are considering defines the offense, and in the same clause uses the language, 'except druggists or registered pharmacists as hereinafter provided.' Section 5 of the act enumerates the particular condition under which liquor may be delivered to certain persons engaged in the whole drug business and to registered pharmacists actually and in good faith engaged in the retail drug business, these exceptions being coupled with elaborate provisions designed to prevent evasion of the law. The language in section 1, 'except druggists or registered pharmacists as hereinafter provided,' does not set forth, nor does it purport to state, except in most general terms, the nature of the exceptions in favor of druggists and registered pharmacists. It is a mere parenthetical expression thrown in to show that in another part of the act provisions will be found which except certain classes of persons from the operation of the statute. As held in the Oklahoma case just cited [Smythe v. State, 2 Okl.Cr. 286, 101 P. 611.], we think the rule contended for by the appellant should never apply where the

matter of such exception or proviso does not enter into and become a material part of the description of the offense. * * *"

In 1 Am.Jur.2d, Abortion, § 18, p. 198, we find the general rule stated as follows:

"Under statutes which provide in effect for the punishment of anyone who supplies or administers a medicine, drug, or substance to a pregnant woman, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless such act is necessary to preserve her life, the authorities generally hold that the indictment must allege that production of a miscarriage was not necessary to save her life. * * *"

[4] We are forced to conclude that the exception in KSA 21-437—"unless the same shall have been necessary to preserve the life of such woman"—is an integral part of the definition of the offense of abortion, and the failure to negatively aver the exception in the information constituted a fatal defect.

It necessarily results that the conviction must be set aside and the defendant discharged from the judgment and sentence.

It is so ordered.

Approved by the Court.

appeal docketed sub nom. Hanrahan v. Doe, 39 U.S.L.W. 3438 (U.S. Mar. 29, 1971) (No.1522, 1970 Term: renumbered No. 70-105, 1971 Term), stay issued (Marshall, J. Sup. Ct. Feb. 10, 1971)

Jane DOE and Sally Roe, suing on behalf of themselves and all others similarly situated, and David N. Danforth, M.D., Charles Fields, M.D., Ralph M. Wynn, M.D., and Frederick P. Zuspan, M.D., suing on behalf of themselves and all others similarly situated, Plaintiffs,

Mary Poe, by her mother, Pauline Poe, suing on behalf of herself, and all others similarly situated, Intervening Plaintiff,

v.

William J. SCOTT, Attorney General of the State of Illinois, and Edward V. Hanrahan, State's Attorney of Cook County, Illinois, Defendants,

Dr. Bart Heffernan, Intervening Defendant.

Civ. A. No. 70 C 395.

United States District Court, N. D. Illinois, E. D.

Jan. 29, 1971.

Action for declaratory and injunctive relief challenging constitutionality of Illinois abortion statute. The three-judge District Court, Swygert, Chief Circuit Judge, held that the Illinois abortion statute, by forcing the birth of every fetus, no matter how defective or how intensely unwanted by its future parents, displayed no legitimately compelling state interest in fetal life which would justify intrusion on woman's privacy which is involved in forcing her to bear an unwanted child; consequently, during the early stages of pregnancy—at least during the first trimester—the state may not prohibit, restrict or otherwise limit women's access to abortion procedures performed by licensed physicians operating in licensed facilities.

Plaintiffs' motion for summary judgment granted and defendants' motion denied.

Campbell, Senior District Judge, dissented and filed opinion.

See also, D.C., 310 F.Supp. 688.

1. Declaratory Judgment ⇐303
Injunction ⇐114(3)

The Illinois Attorney General, although not made the chief prosecutor by criminal statutes, was a proper party defendant in action for declaratory and injunctive relief challenging constitutionality of the Illinois abortion statute. S.H.A.Ill. ch. 38, § 23–1; 28 U.S.C.A. §§ 1331, 1343, 2201, 2202, 2281, 2284; 42 U.S.C.A. § 1983.

2. Constitutional Law ⇐42

Female plaintiffs who alleged that operation of Illinois abortion statute deprived them of asserted right to terminate unwanted pregnancies in the state of their residence and who asserted that they had been injured either by having been forced to bear unwanted children or by having to travel to foreign states to obtain abortions had standing to raise claims respecting constitutionality of the abortion statute. S.H.A.Ill. ch. 38, § 23–1; 28 U.S.C.A. § 1331, 1343, 2201, 2202, 2281, 2284; 42 U.S.C.A. § 1983.

3. Constitutional Law ⇐42

Physician plaintiffs had standing to raise claims of their patients with respect to constitutionality of Illinois abortion statute. S.H.A.Ill. ch. 38, § 23–1; 28 U.S.C.A. §§ 1331, 1343, 2201, 2202, 2281, 2284; 42 U.S.C.A. § 1983.

4. Criminal Law ⇐13

Illinois statute prohibiting all abortions except those performed by physician in licensed medical facility because "necessary for the preservation of the woman's life" was unconstitutionally vague. S.H.A.Ill. ch. 38, § 23–1(b).

5. Constitutional Law ⇐82

Matters pertaining to procreation, as well as to marriage, the family, and sex are surrounded by a zone of privacy which protects activities concerning such matters from unjustified governmental intrusion. S.H.A.Ill. ch. 38, § 23–1(b); U.S.C.A.Const. Amend. 14.

6. Abortion ⇐1

Illinois abortion statute, by requiring a woman to risk physical and emotional harm short of death when a therapeutic abortion would remove that risk, did not bear scrutiny as a health measure for the benefit of women. S.H.A.Ill. ch. 38, § 23–1(b).

7. Abortion ⇐1

Illinois abortion statute, by forcing the birth of every fetus, no matter how defective or how intensely unwanted by its future parents, displayed no legitimately compelling state interest in fetal life which would justify intrusion on woman's privacy which is involved in forcing her to bear an unwanted child; consequently, during the early stages of pregnancy—at least during the first trimester—the state may not prohibit, restrict or otherwise limit women's access to abortion procedures performed by licensed physicians operating in licensed facilities. S.H.A.Ill. ch. 38, § 23–1(b); U.S.C.A.Const. Amend. 14.

Sybille Fritzsche, The Roger Baldwin Foundation of ACLU, Inc., Susan Grossman, Chicago, Ill., for plaintiffs; Marshall Patner, Patner & Karaganis, Chicago, Ill., of counsel.

Gordon H. S. Scott, Legal Aid Bureau, Chicago, Ill., for intervening plaintiff Mary Poe.

William J. Scott, Atty. Gen., Bernard Genis, Asst. Atty. Gen., Edward V. Hanrahan, State's Atty., Daniel Coman, James C. Murray, Asst. State's Attys., for defendants.

Dennis J. Horan, Thomas M. Crisham and Jerome A. Frazel, Hinshaw, Culbertson, Moelmann, Hoban & Fuller, Chicago, Ill., for intervening defendant Bart Heffernan.

Before SWYGERT, Chief Circuit Judge, ROBSON, Chief District Judge, and CAMPBELL, Senior District Judge.

MEMORANDUM OPINION

SWYGERT, Chief Circuit Judge.

This is an action for declaratory and injunctive relief brought to declare that the Illinois abortion statute [1] is violative of the United States Constitution for one or more reasons.[2] After a three-judge district court was convened the parties were ordered to restrict their arguments to the allegations that the statute is unconstitutionally vague and unconstitutionally invades the privacy of pregnant women. Oral argument was heard, and the case is now before us on a multiplicity of motions including cross-motions of plaintiffs and defendants for summary judgment.

Plaintiffs Doe and Roe, suing anonymously on behalf of themselves and all other women similarly situated, assert that they were unable to obtain legal, medically safe abortions in Illinois because their physicians reasonably believed that they could not perform such an operation upon the plaintiffs without fear of prosecution by defendant law enforcement officials pursuant to the challenged statute. Plaintiff Doe, a woman of means, subsequently had a successful abortion performed in Great Britain, while plaintiff Roe, who is indigent, was compelled to bear an unwanted child since the option of a foreign abortion was economically foreclosed. Plaintiffs Danforth, Fields, Wynn and Zuspan, all licensed physicians, sue on behalf of themselves, and all other similarly situated physicians, alleging that the existence of the challenged statute interferes with and adversely affects their

1. Ill.Rev.Stat., ch. 38, § 23–1 (1969).

2. Jurisdiction is based upon 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331, 1343, 2201, 2202, 2281 and 2284.

ability to conduct their medical practices with proper regard for their patients' best interests. Intervening plaintiff Poe is a high school girl who was pregnant as a result of a forcible rape and sues anonymously by her mother as next friend, asserting the same claims as Doe and Roe.[3]

The principal defendants are William J. Scott, Attorney General of the State of Illinois, and Edward V. Hanrahan, State's Attorney of Cook County, Illinois. Both are law enforcement officials of the State of Illinois who are charged with enforcing its laws, including the challenged statute. Intervening defendant Heffernan is a licensed physician who has been granted leave to appear herein as guardian *ad litem* for those conceived but not yet born.

[1] Defendant Scott asserts that he is not a proper party to this action. Although the Illinois statutes do not make the attorney general the chief prosecutor pursuant to the state's criminal statutes, the leading Illinois case clothes his office with the same authority as attorneys general at the common law. In Fergus v. Russel, 270 Ill. 304, 110 N.E. 130 (1915), the Illinois Supreme Court held that, although the state legislature may confer powers additional to those inherent in the common law office of attorney general, it may not deprive the office of any of its historical powers and duties as chief legal representative of the state.[4] The court further stated, "[A]t common law the Attorney General was the law officer of the crown and its chief representative in the courts."[5] Furthermore, the attorney general has conceded that he is required to represent the people of the state before the supreme court in all matters in which their interests are apparent and to assist in the prosecution of any criminal trial when he believes the people's interest requires it.[6] Indeed, the overlap of the powers and duties of the state's attorneys of the several counties and the attorney general is such that it appears that, where their powers are concurrent, either officer may initiate appropriate proceedings in the name of the state if the other has not acted.[7] We hold, therefore, that the attorney general is a proper party defendant in this action.

[2, 3] Defendants challenge the standing of the plaintiffs to raise the claims which they assert. The female plaintiffs allege that the operation of the statute deprived them of their asserted right to terminate unwanted pregnancies in the state of their residence. They assert that they have been injured either by having been forced to bear unwanted children or by having to travel to foreign states to obtain abortions by qualified medical personnel. We have no doubt that, "On the basis of plaintiffs' substantive contentions, * * * there * * * exists a 'nexus between the status asserted by the [female plaintiffs] and the claim(s) (they present).'"[8] The standing requirements of Flast v. Cohen, 392 U.S. 83, 102, 88 S.Ct. 1942, 20 L.Ed. 2d 947 (1968), are thus satisfied by the litigative posture of the female plaintiffs. Moreover, the physician-plaintiffs have standing to raise the claims of their

3. On March 23, 1970, Poe moved for leave to intervene and for the issuance of a temporary restraining order enjoining the defendants from attempting to enforce the Illinois statute against Poe's physician for terminating her pregnancy. On March 27 Poe was allowed to intervene, but her request for a restraining order was denied. On March 30 the Court of Appeals for the Seventh Circuit issued the temporary restraining order requested by Poe.

4. 270 Ill. at 337-339, 110 N.E. at 143-144.

5. 270 Ill. at 336, 110 N.E. at 143.

6. Ill.Rev.Stat. ch. 14, § 4 (1969).

7. *E. g.*, People ex rel. Kunstman v. Shinsaku Nagano, 389 Ill. 231, 59 N.E.2d 96 (1945); People ex rel. Miller v. Fulbrewider, 329 Ill. 65, 160 N.E. 175 (1928). *But see* People v. Flynn, 375 Ill. 366, 369, 31 N.E.2d 591, 593 (1940).

8. Roe v. Wade, 314 F.Supp. 1217, 1220 (N.D.Tex.1970) (citing Flast v. Cohen, 392 U.S. 83, 102, 88 S.Ct. 1942, 20 L.Ed. 2d 947 (1968)).

patients even if we assume that no independent claim of theirs could withstand a motion for judgment on the pleadings.[9] All plaintiffs thus have standing to raise the claims which they assert.

I

[4] Plaintiffs contend that the Illinois abortion statute must be adjudged unconstitutionally vague. We agree. The statute prohibits all abortions except those "performed by a physician * * * in a licensed hospital or other licensed medical facility because *necessary for the preservation of the woman's life.*" [10] Plaintiffs point to the italicized language as the basis for their assertion that the statute is invalid under the due process clause of the fourteenth amendment because of its imprecision. It is clear that, as the Supreme Court has said:

> No one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the State commands or forbids. * * * "[A] statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law." [11]

The question thus becomes whether men of ordinary intelligence must guess at the meaning of the words, "necessary for the preservation of the woman's life."

We note at the outset that these words, or substantially identical ones, have convinced some courts that they are incapable of certain interpretation,[12] and other courts have disagreed.[13] If courts cannot agree on what is the essential meaning of "necessary for the preservation of the woman's life" and like words, we fail to see how those who may be subject to the statute's proscriptions can know what it prohibits. On the issue of vagueness, we are in agreement with the reasoning of People v. Belous [14] and Roe v. Wade.[15] One need not inquire in great depth as to the meaning of such words as "necessary" and "preserve" to conclude that the holdings of those cases are correct. "Necessary" has been characterized as vague by the United States Supreme Court [16] and has been similarly described by other courts.[17] It is "a word susceptible of various meanings. It may import absolute physical necessity or inevitability, or it may import that which is only convenient, useful, appropriate, proper, or conducive to the end sought." [18]

9. Griswold v. Connecticut, 381 U.S. 479, 481, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); Barrows v. Jackson, 346 U.S. 249, 257, 73 S.Ct. 1031, 97 L.Ed. 1586 (1953).

10. Ill.Rev.Stat., ch. 38, § 23-1(b) (1969) (emphasis added).

11. Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 619, 83 L.Ed. 888 (1939); *accord*, Jordan v. DeGeorge, 341 U.S. 223, 71 S.Ct. 703, 95 L.Ed. 886 (1951); Connally v. General Constr. Co., 269 U.S. 385, 46 S.Ct. 126, 70 L.Ed. 322 (1926).

12. *E. g.*, Roe v. Wade, 314 F.Supp. 1217, 1223 (N.D.Tex.1970); United States v. Vuitch, 305 F.Supp. 1032, 1034 (D.D.C. 1969); People v. Belous, 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194, 197 (1969), cert. denied, 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970).

13. *E. g.*, Babbitz v. McCann, 310 F.Supp. 293, 298 (E.D.Wis.1970); Rosen v. Louisiana State Board of Medical Examiners, 318 F.Supp. 1217, (E.D.La.1970); Steinberg v. Rhodes, 321 F.Supp. 741 (N.D. Ohio, filed Dec. 18, 1970).

14. 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), cert. denied, 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970).

15. 314 F.Supp. 1217 (N.D.Tex.1970).

16. Yu Cong Eng v. Trinidad, 271 U.S. 500, 517-518, 46 S.Ct. 619, 70 L.Ed. 1059 (1926).

17. *E. g.*, Phillips v. Borough of Folcroft, 305 F.Supp. 766, 770-771 (E.D.Pa.1969); Westphal v. Westphal, 122 Cal.App. 379, 382, 10 P.2d 119, 120 (1932).

18. Black's Law Dictionary 1181 (4th ed. 1957).

The word "preserve" is similarly susceptible of so broad a range of connotations as to render its meaning in the statute gravely amorphous, since it may mean anything from maintaining something in its status quo to preventing the total destruction of something.[19] The treating physician who believes an abortion is medically or psychiatrically indicated thus finds himself threatened with becoming a felon as well as with the possibility of losing his right to practice his profession if he errs in the legal interpretation of a penal statute, the words of which have not been sufficiently definite for courts to agree on their meaning.[20] This is precisely the kind of situation that the void-for-vagueness doctrine is intended to prevent.

II

[5] Aside from the fact that the statute is vague, its practical effect is to make abortion unavailable to women unless there is a reasonable certainty that death will result from a continuation of pregnancy. This practical effect of the statute constitutes an intrusion on constitutionally protected areas too sweeping to be justified as necessary to accomplish any compelling state interest. These protected areas are women's rights to life, to control over their own bodies, and to freedom and privacy in matters relating to sex and procreation.

The Supreme Court has long recognized that a person possesses a fundamental, constitutionally protected right to privacy and freedom in certain personal and intimate matters, especially those pertaining to the home and family.[21] This right was developed and applied by the Supreme Court to strike down a state's birth control statute in Griswold v. Connecticut.[22] The Court there held that "specific guarantees in the Bill of Rights have penumbras, formed by emanations from those guarantees that help give them life and substance. * * * Various guarantees create zones of privacy."[23] *Griswold* set out in broad terms the right of married couples to be free from governmental intrusion into their intimate affairs:

> We cannot distinguish the interests asserted by the plaintiffs in this case from those asserted in *Griswold*. In both, "[t]he essence of the interest sought to be protected * * * is the right of choice over events which, by their character and consequences, bear in a fundamental manner on the privacy of individuals."[24] It is as true after conception as before that "there is no topic more closely interwoven with the intimacy of the home and marriage than that which relates to the conception and bearing of progeny."[25] We believe that *Griswold* and related cases establish that matters pertaining to procreation, as

19. Webster's Third New International Dictionary 1794 (1961).

20. The problem faced by a treating physician in Illinois is as described in Roe v. Wade, 314 F.Supp. 1217, 1223 (N.D.Tex. 1970):

> How *likely* must death be? Must death be certain if the abortion is not performed? Is it enough that the woman could not undergo birth without an ascertainably higher possibility of death than would normally be the case? What if the woman threatened suicide if the abortion was not performed? How *imminent* must death be if the abortion is not performed? Is it sufficient if having the child will shorten the life of the woman by a number of years? These questions simply cannot be answered.

21. *See, e. g.*, Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 67 L.Ed. 1042 (1923); Pierce v. Society of Sisters, 268 U.S. 510, 534, 45 S.Ct. 571, 69 L.Ed. 1070 (1925); Prince v. Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 88 L.Ed. 645 (1944); Loving v. Virginia, 388 U.S. 1, 12, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967); and Stanley v. Georgia, 394 U.S. 557, 564, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969).

22. 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965).

23. *Id.* at 484, 85 S.Ct. at 1681.

24. Roe v. Wade, 314 F.Supp. 1217, 1221 (N.D.Tex.1970).

25. Babbitz v. McCann, 310 F.Supp. 293, 299 (E.D.Wis.1970).

well as to marriage, the family, and sex are surrounded by a zone of privacy which protects activities concerning such matters from unjustified governmental intrusion.[26]

We do not agree with the defendants that the choice whether to have a child is protected before conception but is not so protected immediately after conception has occurred.[27] A woman's interest in privacy and in control over her body is just as seriously interfered with by a law which prohibits abortions as it is by a law which prohibits the use of contraceptives. The majority of courts which have considered the question have so held, concluding that a woman has a fundamental interest in choosing to terminate a pregnancy. In People v. Belous, *supra*, the California Supreme Court struck down that state's abortion statute, holding:

> The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a "right of privacy" or "liberty" in matters related to marriage, family, and sex.[28]

In United States v. Vuitch, *supra*, a single district court judge struck down a portion of the District of Columbia abortion statute, saying:

> There has been, moreover, an increasing indication in decisions of the Supreme Court of the United States that as a secular matter a woman's liberty and right of privacy extends to family, marriage and sex matters and may well include the right to remove an unwanted child at least in early stages of pregnancy. * * * Matters have certainly reached a point where a sound, informed interest of the state must affirmatively appear before the state infringes unduly on such rights.[29]

More recently, in Babbitz v. McCann,[30] and in Roe v. Wade, [31] three-judge courts found that the right to choose whether to bear a child was fundamental and struck down state abortion statutes.

[6] Of course, the determination that women have a fundamental interest in choosing whether to terminate pregnancies does not establish that the Illinois statute is unconstitutional. The critical issue is whether the state has a compelling interest in preventing abortions in the early stages of pregnancy except where the death of the woman is reasonably certain.[32] A stat-

26. As former Supreme Court Justice Tom C. Clark has said:
> The result of [Griswold and its predecessors] is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children, and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution.

Clark, Religion, Morality, and Abortion: A Constitutional Appraisal, 2 Loyola Univ. (L.A.) L.Rev. 1, 8 (1969).

27. Again, Mr. Justice Clark observed:
> [A]bortion falls within that sensitive area of privacy—the marital relation. One of the basic values of this privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was to prevent formation of the fetus. This, the Court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed?

Id. at 9.

28. 71 Cal.2d 954, 963, 80 Cal.Rptr. 354, 359, 458 P.2d 194, 199 (1969), cert. denied, 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970).

29. 305 F.Supp. 1032, 1035 (D.D.C.1969).

30. 310 F.Supp. 293 (E.D.Wis.1970).

31. 314 F.Supp. 1217 (N.D.Tex.1970).

32. As the court stated in Roe v. Wade, 314 F.Supp. 1217, 1222 (N.D.Tex.1970):
> Since the Texas Abortion Laws infringe upon plaintiffs' fundamental right to choose whether to have children, the burden is on the defendant to demonstrate to the satisfaction of the Court that such infringement is necessary to support a compelling state interest.

ute which requires a woman to risk physical and emotional harm short of death when a therapeutic abortion would remove that risk does not bear scrutiny as a health measure for the benefit of women.

[7] Moreover, a statute which forces the birth of every fetus, no matter how defective or how intensely unwanted by its future parents, displays no legitimately compelling state interest in fetal life, especially when viewed with regard for the countervailing rights of pregnant women. We do not believe that the state has a compelling interest in preserving all fetal life which justifies the gross intrusion on a woman's privacy which is involved in forcing her to bear an unwanted child. We therefore rule that during the early stages of pregnancy—at least during the first trimester—the state may not prohibit, restrict or otherwise limit women's access to abortion procedures performed by licensed physicians operating in licensed facilities.

In holding that the state has not shown sufficient justification to permit us to uphold its abortion statute in its entirety, we are in agreement with the court's statement in Babbitz v. McCann:

> The defendants urge that the state's interest in protecting the embryo is a sufficient basis to sustain the statute. Upon a balancing of the relevant interests, we hold that a woman's right to refuse to carry an embryo during the early months of pregnancy may not be invaded by the state without a more compelling public necessity than is reflected in the statute in question.[33]

Accordingly, the Illinois abortion statute, Illinois Revised Statutes, Chapter 38, Section 23–1, is unconstitutional because it is impermissibly vague and unduly infringes women's right to privacy insofar as it restricts or prohibits the performance of abortions during the first trimester of pregnancy by licensed physicians in a licensed hospital or other licensed medical facility.

ORDER

1. The foregoing opinion shall stand as findings of fact and conclusions of law.

2. The motion of plaintiffs for summary judgment is hereby granted, and the motion of defendants for summary judgment is hereby denied.

3. The motion of defendant Scott to dismiss this action as against him is hereby denied.

4. All other motions presently outstanding are hereby denied to the extent not expressly granted herein or mooted by or subsumed in the foregoing opinion or this order.

It is therefore ordered, adjudged and decreed:

1. That the Illinois abortion statute, Illinois Revised Statutes, Chapter 38, Section 23–1, be and the same is hereby declared to be violative of the Constitution of the United States and is null and void insofar as it restricts or prohibits the performance of abortions during the first trimester of pregnancy by licensed physicians in a licensed hospital or other licensed medical facility.

2. That the defendants, their officers, agents, servants, employees, and attorneys, and those persons who act in active concert or participation with them be and the same are hereby permanently enjoined, without bond, from executing or enforcing, or threatening to execute or enforce, the Illinois abortion statute, Illinois Revised Statutes, Chapter 38, Section 23–1 against physicians licensed to practice medicine and surgery in all its branches performing abortions during the first trimester of pregnancy in a licensed hospital or other licensed medical facility.

See also Bates v. Little Rock, 361 U.S. 516, 524, 80 S.Ct. 412, 4 L.Ed.2d 480 (1960); Griswold v. Connecticut, 381 U.S. 479, 497, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) (Goldberg, J., concurring).

33. 310 F.Supp. 293, 301 (E.D.Wis.1970).

CAMPBELL, Senior Judge (dissenting).

The typically erudite opinion of our distinguished Chief Judge Swygert excellently presents some philosophical reasons for amendment to or repeal of the existing abortion statute by the Illinois Legislature. I must respectfully disagree however when these reasons are advanced to support a judicial determination that the statute "is unconstitutional because it is impermissibly vague and unduly infringes women's right to privacy." Neither the wisdom of this statute nor its conformity to the accepted mores of Illinois in 1971 is the issue before us. As a federal court we are concerned only with the limited question of whether in enacting this statute the people of Illinois have exceeded the limitations of the United States Constitution.

By their foregoing decision and order in this case concluding that those limits have been exceeded, my learned brothers strike down a state statute which has been enforced for one hundred years [1] and impose upon the people of Illinois their own views on this most important and controversial issue concerning public health and morals. In my view this unwarranted intrusion by the federal judiciary into the affairs of Illinois in the name of constitutional interpretation is far beyond properly limited federal powers and is not supported by the facts of this case nor the precedents cited by my brethren.

The basis of the majority decision is twofold: (1) the Illinois statute (and particularly the exception found therein) is so vague as to render it unconstitutional; and (2) by prohibiting the destruction of fetal life the statute invades the privacy of the women and the family entities of Illinois.

On the vagueness question I first observe that we have before us no contention by any party that an actual situation exists where a licensed physician acting in good faith is in jeopardy of prosecution for performing an abortion he believed to be "necessary for the preservation of the woman's life." In other words we are presented with no actual circumstance where the vagueness question is in issue. The rather forced game of semantics urged by plaintiffs and adopted by the majority has not presented any *actual* controversy but is merely a convenient vehicle for these plaintiffs to challenge a law which they believe is unwise and which they have thus far despite heroic efforts been unable to repeal or amend by the legislative process.[2]

A perusal of state and federal criminal codes reveals numerous examples of statutes which have been held constitutional and which are not as clear and definite as this one. Indeed Chief Judge Swygert, in writing his court's opinion upholding the constitutionality of the Illinois disorderly conduct statute, found that the language of that statute prohibiting any act done in "such unreasonable manner as to alarm or disturb another" was not unconstitutionally vague. As stated by him in that opinion: "The Constitution does not require impossible standards of specificity in penal statutes. It requires only that the statute convey 'sufficiently definite warning as to the proscribed conduct when measured by common understanding and practices.'" United States v. Woodard, 376 F.2d 136, 140 (7th Cir. 1967).

His opinion goes on to state, "The statute proscribes conduct that is so unreasonable as to 'alarm or disturb' another and provoke a 'breach of the peace'. The term 'breach of the peace' has never had a precise meaning in relation to specific conduct. Yet from its early common law origin to the present it has received a fairly well defined gloss." (Id. at 141). In our case, how-

1. The present statute is essentially the same as that enacted in 1874. (R.S. 1874, Ch. 38, Div. 1, § 3.)

2. Attempts to amend or repeal the present statute failed in the last (1969) session of the General Assembly. New proposals have already been introduced in the present (1971) session.

ever, the same judge concludes that men and women of ordinary intelligence cannot understand the essential meaning of the words, "necessary for the preservation of the woman's life." I find it difficult to reconcile the reasoning in the *Woodard* case with that set forth in the opinion of the majority herein.

The words of the Illinois Abortion Statute taken in their ordinary meaning sufficiently convey definite warning as to the proscribed conduct and "have over a long period of years proved entirely adequate to inform the public, including both lay and professional people, of what is forbidden." Steinberg v. Rhodes, 321 F.Supp. 741, 745 (N.D.Ohio, 1970); Babbitz v. McCann, 310 F.Supp. 293, 297 (E.D.Wis.1970). The statement of the court in the *Steinberg* opinion is appropriate here:—"The problem of the plaintiffs is not that they do not understand, but that basically they do not accept, its proscription." 321 F.Supp. at p. 745.

I find the second conclusion of the majority, that the statute is not supported by a sufficient legitimate state interest, even more disconcerting. As the majority correctly points out, the determination that women have a fundamental interest in choosing whether to terminate pregnancies does not in and of itself establish that the Illinois statute is unconstitutional. The critical issue is whether the state has a sufficient interest in preventing abortion to justify its prohibition. My brothers conclude that the State of Illinois does not have a sufficient interest in preserving fetal life to support the statute before us, when the same is viewed with regard for countervailing rights to terminate pregnancies. It is at this juncture that I again part company with my brothers.

We, as did the Illinois Legislature, have before us the following undisputed facts relating to fetal life. Seven weeks after conception the fertilized egg develops into a well proportioned small scale baby. It bears all of the familiar external features and all the internal organs of an adult human being. It has muscles; hands with fingers and thumbs; and the legs have recognizable knees, ankles and toes.

The brain is operative and sends out impulses that coordinate the function of the other organs. Brain waves have been noted at 43 days. The heart beats; the stomach produces digestive juices; the liver manufactures blood cells; and the kidneys begin to function by extracting uric acid from the blood.

In the third month it can kick its legs, turn its feet, curl and fan its toes, make a fist, move its thumb, bend its wrist, turn its head, and even open its mouth and swallow and drink the amniotic fluid that surrounds it. Thumb sucking has been noted at this age and the first respiratory motions move fluid in and out of its lungs with inhaling and exhaling respiratory movements.

In the twelfth week it can move its thumb, in opposition to its fingers. It swallows regularly. It has active reflexes. The facial expressions of a fetus in its third month are already similar to the facial expression of its parents. By the end of that first trimester the fetus is a sentient moving being.

In the third month finger nails appear; sexual differentiation is apparent in both internal and external organs; and vocal chords are completed.

From the twelfth to the sixteenth week the child grows to eight or ten inches in height and receives oxygen and food from its mother through the placental attachment. In the fifth month it gains two inches in height and ten ounces in weight. A doctor will soon hear the heart beat with his stethoscope. It sleeps and wakes and may be awakened by external vibrations.

In the sixth month the fetus develops a strong muscular grip with its hands; starts to breathe regularly and can maintain a respiratory response for twenty-four hours if born prematurely. It may even have a slim chance of surviving in an incubator. A child has been known to survive between twenty to twenty-five weeks old. Indeed, as medical science progresses in the field of de-

tection the date of potential viability moves continually closer to earlier stages of gestation.

Dr. Arnold Gesell, in his publication. "*The Embryology of Behavior*,[3] notes:—

"Our own repeated observation of a large group of fetal infants (an individual born and living at any time prior to forty weeks gestation) left us with no doubt that psychologically they were individuals. Just as no two looked alike, so no two behaved precisely alike. One was impassive when another was alert. Even among the youngest there were discernible differences in vividness, reactivity and responsiveness. These were genuine individual differences, already prophetic of the diversity which distinguishes the human family."

Similar facts of fetal life are discussed in detail in a recently published Law Review article, Byrn, Abortion-On-Demand: Whose Morality? 46 N.D. Law. 5 (1970). Professor Byrn concludes:—

"In summary: at eight weeks, after which the great majority of abortions are performed, the fetus is irreversibly organized into a recognizable human-child, is responsive to stimulation, and is possessed of a pumping heart, a functioning circulatory system, an active brain and all other internal organs. From the practical scientific point of view, 'By the eighth week the embryo or fetus, as we now call it, is an unmistakable human being * * *.'"

This author also points out that abortion is a violent procedure regardless of the stage of pregnancy. Byrn, Supra, p. 32.

Professor Byrn also relates (at pp. 8–9) the following experience of Paul E. Rockwell, M.D., Director of Anesthesiology at Leonard Hospital, Troy, New York:

"Eleven years ago while giving an anesthetic for a ruptured ectopic pregnancy (at two months gestation) I was handed what I believe was the smallest living human being ever seen. The embryo sac was intact and transparent. Within the sac was a tiny (approx. 1 cm.) human male swimming extremely vigorously in the amniotic fluid, while attached to the wall by the umbilical cord. This tiny human was perfectly developed, with long, tapering fingers, feet and toes. It was almost transparent, as regards the skin, and the delicate arteries and veins were prominent to the ends of the fingers.

"The baby was extremely alive and swam about the sac approximately one time per second, with a natural swimmer's stroke. This tiny human did not look at all like the photos and drawings and models of 'embryos' which I have seen, nor did it look like a few embryos I have been able to observe since then, obviously because this one was alive!

"* * * When the sac was opened, the tiny human immediately lost its life and took on the appearance of what is accepted as the appearance of an embryo at this age (blunt extremities, etc.)

"It is my opinion that if the lawmakers and people realized that very vigorous life is present, it is possible that abortion would be found much more objectionable than euthanasia."

In my opinion the undisputed medical facts of record herein establish a sufficient state interest in the preservation of life to support the constitutionality of the statute before us.

The majority opinion does not hold that the Illinois Statute is void in its entirety or that every statute that prohibits the destruction of fetal life is unconstitutional. Rather, it seems to hold that the people of this State have a legitimate legislative interest in protecting *some* fetal life, but that the present statute which protects, "every fetus, no matter

3. Harper and Brothers, Publishers (1945), at p. 172.

how defective or how intensely unwanted by its future parents, displays no legitimately compelling state interest." I believe what the majority is suggesting is that if the Illinois Legislature had adopted a statute which, while prohibiting abortions generally, permitted the destruction of the "defective" fetus or one that is "intensely unwanted" it would have displayed a legitimate state interest. It seems to me apparent, however, that if the legislature has the power to decide that a *non defective* fetus may not be destroyed, it can also decide that a *defective* fetus may not be destroyed. How much latitude shall judicially be given the legislature in its determination as to what is and what is not a sufficient "defect" to warrant destruction? How unwanted must a potential child be before its parents can demand destruction under the suggested judicial "intensely unwanted" standard? Merely stating these propositions illustrates the extent to which my brothers have wandered into the legislative domain in reaching their decision in this case.

But the majority does not rest its conclusion of unconstitutionality on such a tenuous base. Instead, the majority states: "We therefore rule that during the early stages of pregnancy—at least during the first trimester—the state may not prohibit, restrict or otherwise limit women's access to abortion procedures * * *" The opinion does not explain or even intimate how it arrived at this constitutional conclusion. It appears to me that my brothers have, by judicial fiat, successfully amended the Illinois statute to permit abortions in the first three months of pregnancy. Ironically, their amendment does not even meet sound legislative standards. No where do they explain how the "first trimester" test was arrived at, or what relationship it might have to the previously discussed notions of defectiveness or unwantedness. What rational basis supports their conclusion that the people of Illinois may have a sufficient interest in protecting the life of a fetus which has matured to the first trimester, but that no legitimate interest exists for protecting a life of a fetus a few days younger? I believe the Illinois Legislature, in adopting the present statute, was less arbitrary even if not as competent as my brothers on these social and moral matters. In my opinion, however, the legislature alone should determine what value society will place on this form of life, regardless of the age of development.

Thus far I have avoided any discussion of the sensitive subject of whether fetal life is "human" life. Admittedly physicians argue as to what point in the fetal development human life commences. As former Supreme Court Justice Tom C. Clark states in the Law Review article quoted by the majority, "Some physicians argue that abortion should be permitted with impunity at any time up to the sixth month of pregnancy since prior to that time the fetus is no more than a growing plant. On the other hand, many eminent physicians believe that the fertilized ovum has human life from the time of conception. In support of this argument they refer to the International Code of Medical Ethics, which states that a physician will maintain the utmost respect for human life, from the time of its conception." Clark, Religion, Morality and Abortion: A Constitutional Appraisal, 2 Loy.U.L.Rev. 1, 5 (1969). Assuming *arguendo* that fetal life is human life, can there be any question but that the State of Illinois has a sufficient legislative interest in its protection? And, in view of the varied opinions in medical science, is not the determination of when human life commences better left to the legislature, rather than the courts? This was the conclusion reached by Mr. Justice Clark in the above quoted article. Significantly, while liberally quoting Justice Clark's article on the subject of abortion (see notes 26 and 27), the majority conveniently ignores its conclusion and admonition as follows:—

"Accommodation of conflicting doctrine is more difficult to achieve in

the judicial than in the legislative process. Courts cannot reach out to reform our society. A problem comes to the Court in the form of a justiciable issue and is narrowly drawn, rendering the Court's ruling contracted and finespun. Legislatures, on the other hand, have such facilities for investigation as hearings and may address themselves to the necessities of broad social needs and the correction of evils, both probable and existing. As Mr. Justice Cardozo said, 'Legislation can eradicate a cancer, right some hoary wrong, correct some definitely established evil, which defies the feebler remedies, the distinctions and the fictions familiar to the judicial process.'

"The courts work on a case-by-case system which deals with the past rather than the future. Society would not have the benefit of the sweeping effect of a statute, nor would the doctor have the protection that he is entitled to receive. The case method would be slow, expensive, and possibly disastrous. It is for the legislature to determine the proper balance, i. e., that point between prevention of conception and viability of the fetus which would give the State the compelling subordinating interest so that it may regulate or prohibit abortion without violating the individual's constitutionally protected rights." (At pp. 10–11).

To support their conclusion that the people of Illinois have exceeded the proper bounds of legislative interest, the majority primarily rely on the rationale of the Supreme Court in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510. But *Griswold* held only that a statute which forbade the use of contraceptives by married couples violated their right to privacy. In writing the opinion of the Court, Mr. Justice Douglas indicated that the Connecticut statute was "unnecessarily broad" and prevented activities which might otherwise be subject to state regulation. (381 U.S. 485, 85 S.Ct. 1678). The more thorough concurring opinion, written by Mr. Justice Goldberg, stressed that there was in that case no showing that the statute was necessary to accomplish a permissible state interest.

In this case, however, there is in my opinion a valid and permissible state interest—the protection of human life or at least the protection of potential human life in the fetus. In my opinion the statute in question is no broader than is necessary to accomplish this valid and permissible state interest even though it does not distinguish or provide exceptions, as my brothers would prefer, for those which are "defective" or "intensely unwanted," or have not matured to "the first trimester of pregnancy."

In citing *Griswold*, the majority concludes: "we cannot distinguish the interests asserted by the plaintiffs in this case from those asserted in *Griswold*." In other words, in their views, there is no distinction that can be made between prohibiting the use of contraceptives and prohibiting the destruction of fetal life, which as explained above may reasonably be construed to be human life. I find this assertion incredible. Contraception prevents the creation of new life. Abortion destroys existing life. Contraception and abortion are as distinguishable as thoughts or dreams are distinguishable from reality.

As for myself I am confronted with and bound by the plain facts before us in this case and I must conclude that the people of Illinois have a legitimate and sufficient interest in protecting fetal life to support the statute here considered. I find nothing in the Court's teachings in *Griswold* to the contrary.

No individual right or freedom is ever advanced in this country through an unwarranted intrusion of the judiciary into the proper province of the legislature. Indeed, in these days of pressure groups regularly seeking from courts that which only legislatures can properly give, constitutional government is weakened each time courts place their personal philosophical views above the law.

I would grant the motion of defendants for summary judgment and leave the plaintiffs' cause where under the Constitution it belongs—in the Illinois Legislature.

Item No. 19

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF UTAH

CENTRAL DIVISION

JANE DOE, Plaintiff, vs. CALVIN L. RAMPTON, Governor of the State of Utah; and VERNON B. ROMNEY, Attorney General of the State of Utah, Defendants.	TEMPORARY RESTRAINING ORDER No. C-234-70

The above entitled matter having come duly before the above entitled Court, the Honorable Willis W. Ritter presiding, on Monday, the 14th day of September, 1970, upon the plaintiff's Application for a Temporary Restraining Order, and the plaintiff being represented by counsel, David S. Dolowitz, Esq., and the defendants being represented by counsel, Joseph P. McCarthy, Esq., and the Court having considered the records, files, papers and the arguments of counsel in the foregoing matter, this Court enters the following findings of fact:

FINDINGS OF FACT

1. That plaintiff Jane Doe is pregnant, being, upon her doctor's advice, in her tenth to twelfth week of pregnancy.

2. That plaintiff Jane Doe has three children.

3. That plaintiff Jane Doe is currently receiving public welfare assistance from the State of Utah.

4. That plaintiff Jane Doe desires to be aborted from her pregnancy.

5. That the danger in performing an abortion increases substantially after the twelfth week.

6. That plaintiff Jane Doe desires and Dr. X is willing to perform, a therapeutic abortion, aborting and terminating the current pregnancy of the plaintiff.

From the foregoing findings of fact, this Court makes the following conclusions of law:

CONCLUSIONS OF LAW

1. That the plaintiff Jane Doe will suffer immediate and irreparable injury if the defendants are not enjoined and restrained from enforcing the provisions of Sections 76-2-1 and 76-2-2, Utah Code Annotated 1953.

2. That the issues presented in this case are substantial issues of federal constitutional law and it appears from examination of the applicable cases, to wit: ***Griswold v. Connecticut,*** 381 U.S. 479; ***People v. Bellous,*** 80 Cal. Rptr. 354, 458 P.2d 194 (1969), ***cert. den.*** 38 L.W. 3320, 3325; ***Babbitz v. McCann,*** 310 F. Supp. 293 (E.D. Wis. 1970); and ***United States v. Vuitch,*** 305 F. Supp. 1032 (D.D.C. 1969); see ***Doe v. Scott***, 310 F. Supp. 689 (N.D. Ill. 1970), ***reversed*** ___ F.2d ___ (7th Cir. 1970), that the plaintiff is likely to prevail on the merits.

3. That no security should be required of the plaintiff for the issuance of this Order.

Accordingly, IT IS HEREBY ORDERED that the Governor of the State of Utah, the Honorable Calvin L. Rampton, and the Attorney General of the State of Utah, the Honorable Vernon R. Romney, defendants in the above entitled matter, are hereby enjoined and restrained from enforcing the provisions of Sections 76-2-1 and 76-2-2, Utah Code Annotated 1953, to plaintiff Jane Doe for securing and to her physician, Dr. X, from providing a therapeutic abortion, aborting and terminating her current pregnancy. This Order shall run for ten days from the signing hereof.

IT IS FURTHER ORDERED that said Order shall be entered without the requirement of the posting of security.

Dated this 14th day of September, 1970.

BY THE COURT:

/s/ WILLIS W. RITTER
Chief Judge

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appeal dismissed for want of juris., 400 U.S. 1 (1970) (per curiam)



Sidney G. BABBITZ, M. D., Plaintiff,

v.

E. Michael McCANN, District Attorney of Milwaukee County, F. Ryan Duffy, Jr., Judge of the County Court, Milwaukee County, Defendants.

No. 69-C-548.

United States District Court, E. D. Wisconsin.

March 5, 1970.

A physician brought an action challenging constitutionality of Wisconsin abortion statute and sought injunctive and declaratory judgment relief. A Three-Judge District Court held that Wisconsin statute making it a criminal offense to perform an abortion except a therapeutic abortion which is necessary to save life of mother is not unconstitutionally vague or a denial of equal protection of the laws, but is an unconstitutional invasion of woman's private right to refuse to carry unquickened embryo during the early months of pregnancy.

Declaratory judgment for plaintiff and injunctive relief denied.

1. Courts ⇐101

Three-judge federal district court had jurisdiction of suit by physician, who was charged with violation of Wisconsin abortion statute, challenging the constitutionality of such statute and seeking injunctive and declaratory relief. 28 U.S.C.A. §§ 1343, 2201, 2202; 42 U.S.C.A. § 1983.

2. Courts ⇐280.4, 508(7)

Notwithstanding determination of three-judge federal district court that certain portions of Wisconsin abortion statute are unconstitutional, there were no special circumstances which would entitle plaintiff physician, challenging validity of statute, to enjoin pending Wisconsin prosecution against him for violation of abortion statute and doctrine of abstention was applied. 28 U.S.C.A. § 2283; W.S.A. 940.04.

3. Courts ⇐280.4

Although three-judge federal district court, applying doctrine of abstention declined to enjoin pending criminal proceedings against plaintiff for violation of Wisconsin abortion statute, court was required to decide merits of request that statute be declared unconstitutional irrespective of its conclusion as to propriety of issuance of injunction. 28 U.S.C.A. §§ 2281, 2283; W.S.A. 940.04.

4. Abortion ⇐1
Constitutional Law ⇐83(1), 250
Criminal Law ⇐13

Wisconsin statute making it a criminal offense to perform an abortion except a therapeutic abortion which is necessary to save life of mother is not unconstitutionally vague or a denial of

equal protection of the laws, but is an unconstitutional invasion of woman's private right to refuse to carry an unquickened embryo during the early months of pregnancy. W.S.A. 940.04, U.S.C.A.Const. Amends. 1, 9, 14.

5. Federal Civil Procedure ⇐1164

Court took judicial notice of fact that there are a number of places throughout world where legal abortions are available.

6. Constitutional Law ⇐83(1)

To justify regulation of such fundamental private rights as marriage, home, children and day-to-day living habits, state must show a compelling need. U.S.C.A.Const. Amend. 9.

7. Parent and Child ⇐1

When measured against claimed rights of an embryo of four months or less, mother's right to refuse to carry an embryo during the early months of pregnancy transcends those of the embryo. W.S.A. 940.04; U.S.C.A.Const. Amend. 9.

8. Abortion ⇐1

It is permisaible for state to require that abortions be conducted by qualified physicians. U.S.C.A.Const. Amend. 9.

Nathaniel Rothstein, Milton R. Bordow and Roy O. Conen, Milwaukee, Wis., for plaintiff.

E. Michael McCann, Dist. Atty., Milwaukee, Wis., for defendants.

Before KERNER, Circuit Judge, and REYNOLDS and GORDON, District Judges.

PER CURIAM.

The plaintiff is a physician who challenges the constitutionality of the Wisconsin abortion statute. He seeks an injunction restraining the defendants from enforcing a part of Wis.Stat. § 940.04 and a judgment declaring it unconstitutional.

A temporary restraining order was denied by the order of a single-judge district court, 306 F.Supp. 400, and the instant three-judge district court was convened to consider the other issues presented. We hold that portions of the statute are constitutionally invalid, but we decline to enjoin the pending state prosecution of the plaintiff.

The plaintiff is being prosecuted by the district attorney of Milwaukee county for allegedly having performed an abortion in violation of § 940.04, Wis. Stats. The statute provides in part as follows:

"(1) Any person, other than the mother, who intentionally destroys the life of an unborn child may be fined not more than $5,000 or imprisoned not more than 3 years or both.

"(2) any person, other than the mother, who does either of the following may be imprisoned not more than 15 years:

"(a) Intentionally destroys the life of an unborn quick child; or

* * * * * *

"(5) This section does not apply to a therapeutic abortion which:

"(a) Is performed by a physician; and

"(b) Is necessary, or is advised by 2 other physicians as necessary, to save the life of the mother; and

"(c) Unless an emergency prevents, is performed in a licensed maternity hospital.

"(6) In this section 'unborn child' means a human being from the time of conception until it is born alive."

The state warrant issued against Dr. Babbits reads as follows:

"That the above named Defendant on the 6th day of September, 1969, in the County of Milwaukee, Wisconsin, did feloniously destroy the life of an unborn child of one, [woman], said offense occurring at number 231 West Wisconsin Avenue, Milwaukee, Wisconsin, said abortion not being advised by two other physicians as necessary to save the life of [woman], the mother of said child, said information being obtained by sworn testimo-

ny of [woman] before the Honorable Christ T. Seraphim, County Judge, acting as magistrate."

[1] The complaint asserts that there is jurisdiction in this court pursuant to 28 U.S.C. § 1343, 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201 and 2202; we agree with such position.

The complaint charges that the Wisconsin statute is unconstitutional for violating the first and fourteenth amendments of the United States Constitution and for abridging the mother's right of privacy. Dr. Babbitz has not been charged with having destroyed an unborn child which was "quick", and therefore subsections (2) and (2) (a) of the statute quoted above are not applicable in the instant case. There is no allegation that the state officials are acting in bad faith in prosecuting Dr. Babbitz.

I. ABSTENTION

[2] The plaintiff has alleged a deprivation of rights secured by the Constitution, and serious federal questions are raised here concerning the constitutionality of certain portions of the Wisconsin abortion statute. Since the complaint seeks injunctive relief and since the statute in question has state-wide operation, the designation of a three-judge court was appropriate under 28 U.S.C. § 2281.

The request for an injunction raises a threshold problem of abstention. Congress, in 28 U.S.C. § 2283, has stated a strong policy of abstention, as follows:

"Stay of State court proceedings. A court of the United States may not grant an injunction to stay proceedings in a State court except as expressly authorized by Act of Congress, or where necessary in aid of its jurisdiction, or to protect or effectuate its judgments."

Except for those rather recent cases which have noted exceptions to the scope of § 2283, the federal courts have generally given the statute literal application. In addition, the policy of abstention has found expression in a long history of judge-made rules of federal judicial forebearance. Mr. Justice Frankfurter's expressions in Railroad Commission of Texas v. Pullman Co., 312 U.S. 496, 500–501, 61 S.Ct. 643, 645, 85 L.Ed. 971 (1941), typify these court-fashioned rules of abstention:

"Few public interests have a higher claim upon the discretion of a federal chancellor than the avoidance of needless friction with state policies, whether the policy relates to the enforcement of the criminal law, Fenner v. Boykin, 271 U.S. 240, 46 S.Ct. 492, 70 L.Ed. 927; Spielman Motor Co. v. Dodge, 295 U.S. 89, 55 S.Ct. 678, 79 L.Ed. 1322; or the administration of a specialized scheme for liquidating embarrassed business enterprises, Pennsylvania v. Williams, 294 U.S. 176, 55 S.Ct. 380, 79 L.Ed. 841, 96 A.L.R. 1166; or the final authority of a state court to interpret doubtful regulatory laws of the state, Gilchrist v. Interborough Co., 279 U.S. 159, 49 S.Ct. 282, 73 L.Ed. 652; cf. Hawks v. Hamill, 288 U.S. 52, 61, 53 S.Ct. 240, 77 L.Ed. 690. These cases reflect a doctrine of abstention appropriate to our federal system whereby the federal courts, 'exercising a wise discretion', restrain their authority because of 'scrupulous regard for the rightful independence of the state governments' and for the smooth working of the federal judiciary."

The abstention policy has also played a role in the development of the law of removal of pending state cases to the federal courts. In City of Greenwood, Miss. v. Peacock, 384 U.S. 808, 828, 86 S.Ct. 1800, 1812, 16 L.Ed.2d 944 (1966), the Supreme Court observed:

"* * * the vindication of the defendant's federal rights is left to the state courts except in the rare situations where it can be clearly predicted by reason of the operation of a pervasive and explicit state or federal law that those rights will inevitably be denied by the very act of bringing the defendant to trial in the state court."

The approach to abstention which this policy requires has been followed by many federal courts without any general exception being recognized for cases arising under 42 U.S.C. § 1983. Boyle v. Landry, 422 F.2d 631 (7th Cir. February 5, 1970); Goss v. Illinois, 312 F.2d 257, 259 (7th Cir. 1963); Smith v. Village of Lansing, 241 F.2d 856 (7th Cir. 1957); Baines v. City of Danville, 337 F.2d 579 (4th Cir. 1964); Vick v. Schiro, 296 F.Supp. 173 (E.D.La.1969). Cf. Cooper v. Hutchinson, 184 F.2d 119 (3rd Cir. 1950).

One of the reasons underlying this practice of refusing to enjoin pending state prosecutions is particularly apposite to the case at bar. In Stefanelli v. Minard, 342 U.S. 117, 72 S.Ct. 118, 96 L.Ed. 138 (1951), a federal court was petitioned to enjoin the use of illegally seized evidence in a state criminal trial. Denying relief, the Supreme Court said, at page 123, 72 S.Ct. at page 121–122:

> "The consequences of exercising the equitable power here invoked are not the concern of a merely doctrinaire alertness to protect the proper sphere of the States in enforcing their criminal law. If we were to sanction this intervention, we would expose every State criminal prosecution to insupportable disruption. Every question of procedural due process of law—with its far-flung and undefined range—would invite a flanking movement against the system of State courts by resort to the federal forum, with review if need be to this Court, to determine the issue. Asserted unconstitutionality in the impaneling and selection of the grand and petit juries, in the failure to appoint counsel, in the admission of a confession, in the creation of an unfair trial atmosphere, in the misconduct of the trial court—all would provide ready opportunities, which conscientious counsel might be bound to employ, to subvert the orderly, effective prosecution of local crime in local courts."

Notwithstanding the impressive authority which would bar our enjoining the prosecution of Dr. Babbitz, he presses us to issue such an injunction. Perhaps he draws comfort from the fact that the United States Supreme Court has on two separate occasions expressly reserved ruling on the question whether the Civil Rights Act suspends the anti-injunction provisions of § 2283. Cameron v. Johnson, 390 U.S. 611, 614, n. 3, 88 S.Ct. 1335, 20 L.Ed.2d 182 (1968); Dombrowski v. Pfister, 380 U.S. 479, 484, n. 2, 85 S.Ct. 1116, 14 L.Ed.2d 22 (1965).

Also, the plaintiff may arguably find support for his position from expressions by several of the justices of the United States Supreme Court. For example, in Gorun v. Fall, 393 U.S. 398, 399, 89 S.Ct. 678, 679, 21 L.Ed.2d 628 (1969), four members of the Court referred to "our recent decisions saying over and over again that a federal claim in a federal court should be decided by the federal court and not relegated to a state tribunal".

Finally, it may seem somewhat anomalous that a court may find a state statute unconstitutional and yet deny an injunction against its enforcement by the state. In effect, such a ruling might protect all persons from prosecution except the very man who has persuaded us of the statute's unconstitutionality.

Notwithstanding these arguments, we do not believe that the circumstances of this case justify an exception to the oft-repeated and strong policy of federal abstention, especially in a criminal case. The forebearance required under § 2283 is not lifted in the case at bar by the teachings of Dombrowski v. Pfister, 380 U.S. 479, 85 S.Ct. 1116, 14 L.Ed.2d 22 (1965). We have already noted that the case at bar does not involve a bad faith enforcement of the abortion statute. In addition, we doubt that the prosecution of Dr. Babbitz has resulted in a chilling of his first amendment rights. A first amendment right is more than a personal right; it is also a public right. When such a right is impinged, the general public is hurt, and the effective functioning of our free society is encum-

bered. This may explain why § 2283 is not strictly applied in first amendment cases. We do not accept the plaintiff's claim that his prosecution under the state abortion statute dampened his first amendment rights.

Although the subject of abortion is fraught with highly emotional pressures, we do not find here any "special circumstances" as discussed in Cameron v. Johnson, 390 U.S. 611, 618, 88 S.Ct. 1335, 20 L.Ed.2d 182 (1968), which would entitle Dr. Babbitz to injunctive action. Cf. Machesky v. Bizzell, 414 F.2d 283 (5th Cir. 1969); Romero v. Weakley, 226 F.2d 399 (9th Cir. 1955); 80 Harv.L.Rev. 604, 608–9 (1967).

We believe we must apply the standard established in Douglas v. City of Jeanette, 319 U.S. 157, 163, 63 S.Ct. 877, 87 L.Ed. 1324 (1943); there the Supreme Court observed that it was Congressional policy to leave to the state courts the trial of state criminal cases, and that such proceedings should be enjoined only in exceptional circumstances. We do not regard this as an exceptional case, and Dr. Babbitz is not entitled to injunctive relief. In the event that the state persists in the prosecution of Dr. Babbitz, we have no reason to doubt that the state courts of Wisconsin will fully vindicate his federal constitutional rights. See Zwicker v. Boll, 270 F.Supp. 131 (W.D.Wis.1967), aff'd 391 U.S. 353, 88 S.Ct. 1666, 20 L.Ed.2d 642 (1968); Soglin v. Kauffman, 286 F.Supp. 851 (W.D.Wis.1968).

[3] Notwithstanding our denial of injunctive relief, a federal court is obliged to weigh separately the issue of declaratory relief. In Zwickler v. Koota, 389 U.S. 241, 254, 88 S.Ct. 391, 399, 19 L.Ed.2d 444 (1967), the Supreme Court held that the federal district court must decide the "merits of the declaratory request irrespective of its conclusion as to the propriety of the issuance of the injunction". Although it was the application for an injunction which triggered the appointment of this three-judge court under § 2281, we do not understand that the denial of injunctive relief precludes us from resolving the declaratory judgment application.

II. VAGUENESS

[4] The plaintiff urges that § 940.04(5), Wis.Stats., is vague and nebulous upon its face. That subsection, quoted above, excepts a therapeutic abortion when it is performed under specified terms. We have examined the challenged phraseology and are persuaded that it is not indefinite or vague. In our opinion, the word "necessary" and the expression "to save the life of the mother" are both reasonably comprehensible in their meaning.

The United States Supreme Court has ruled that a criminal statute must be definite enough to acquaint those who are subject to it with the conduct which will render them liable to its penalties. Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 83 L.Ed. 888 (1939); Connally v. General Construction Co., 269 U.S. 385, 391, 46 S.Ct. 126, 70 L.Ed. 322 (1926). See also Unconstitutional Uncertainty—An Appraisal, 40 Cornell Law Quarterly, 195, 196 (1955).

We believe that § 940.04(5) sets forth with reasonable clarity and sufficient particularity the kind of conduct which will constitute a violation. Jordan v. De George, 341 U.S. 223, 71 S.Ct. 703, 95 L.Ed. 886 (1951); United States v. Ragen, 314 U.S. 513, 62 S.Ct. 374, 86 L.Ed. 383 (1942). In United States v. Wurzbach, 280 U.S. 396, 399, 50 S.Ct. 167, 169, 74 L.Ed. 508 (1930), Mr. Justice Holmes stated:

> "Whenever the law draws a line there will be cases very near each other on opposite sides. The precise course of the line may be uncertain, but no one can come near it without knowing that he does so, if he thinks, and if he does so, it is familiar to the criminal law to make him take the risk."

In People v. Belous, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), the California court found that the words "necessary to preserve her life" in that state's abortion statute were unconstitutionally

vague. While the Wisconsin statute uses slightly different language ("necessary to save"), we doubt that the distinction between the words used in the two statutes is significant. However, we do not share the view of the majority in *Belous* that such language is so vague that one must guess at its meaning.

Slightly different language was before the court in United States v. Vuitch, 305 F.Supp. 1032 (D.D.C.1969), which invalidated an abortion law. That statute contained the following expression: "necessary for the preservation of the mother's life or health". The court concluded that the word "health" was vague both in interpretation and in practice. That precise problem is not presented under the terms of the Wisconsin statute.

Our reading of the Wisconsin statute persuades us that it meets the test set forth by the United States Supreme Court in *Connally*, cited above, 269 U.S. at page 391, 46 S.Ct. at page 127:

> "And a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application, violates the first essential of due process of law."

The plaintiff also charges that there is confusion in subsection (6), which provides that the words "unborn child" mean "a human being from the time of conception until it is born alive". The plaintiff may have medical or even practical justification for his disagreement with the correctness of this statutory definition of an unborn child, but he fails in his effort to convince us that the Wisconsin legislature was vague or indefinite in its choice of language.

III. EQUAL PROTECTION OF THE LAWS

The plaintiff contends that the statute denies to him equal protection of the laws as guaranteed by the fourteenth amendment. It is urged that medical facilities are not constant throughout the state and that a doctor in a rural area in Wisconsin might be justified in performing a "necessary" abortion, whereas a doctor treating the same patient in Milwaukee would be unwarranted in performing the abortion because of the availability in Milwaukee of superior medical facilities.

[5] We find more cogency in the argument that a wealthy woman, but not a poor one, is able, upon demand, to secure a safe and legal abortion in Japan or some other locale in which abortion is permitted. We take judicial notice of the fact that there are a number of places throughout the world where legal abortions are available. We have also considered the argument that an affluent woman, unlike the poor one, may enjoy a long-standing, personal relationship with a well-paid physician, who might more likely be willing or able to persuade his fellow doctors to authorize a therapeutic abortion. We are reluctant to equate these types of inequality with a denial of a protected right under the fourteenth amendment. We know of no analogous situation which goes as far as the plaintiff would have us go in applying the fourteenth amendment to the case at bar.

There is presently pending in the United States Supreme Court a challenge to the practice of imposing a jail term upon a defendant who is unable to pay an assessed fine. Williams v. Illinois, 396 U.S. 1036, 90 S.Ct. 689, 24 L.Ed. 2d 680, probable jurisdiction noted January 19, 1969, being an appeal from People v. Williams, 41 Ill.2d 511, 244 N.E.2d 197 (1969). We cannot anticipate that the decision in the *Williams* case will buttress the plaintiff's contention that there is a denial of equal protection of the laws implicit within the Wisconsin abortion statute.

IV. INVASION OF PRIVATE RIGHTS

The ninth amendment to the United States Constitution provides:

> "The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people."

An examination of recent Supreme Court pronouncements regarding the ninth amendment compels our conclusion that the state of Wisconsin may not, in the manner set forth in § 940.04(1) and (5), Wis.Stats., deprive a woman of her private decision whether to bear her unquickened child.

In terms of the Wisconsin statute, we do not purport to decide the question of a woman's aborting a fetus which has already quickened. We received into evidence the view of a gynecologist that a fetus normally becomes quick at about four and a half months after conception. Dorland's Illustrated Medical Dictionary (24th ed. 1965) defines "quick" as "Pregnant and able to feel the fetal movements." "Quickening" is defined as "The first recognizable movements of the fetus in utero, appearing usually from the sixteenth to the eighteenth week of pregnancy." The plaintiff is being prosecuted under § 940.04(1) and (5); he is not being prosecuted under those portions of § 940.04 which relate to the abortion of a quickened child; therefore, the validity of such provisions are beyond the scope of this opinion.

While problems of over-population, ecology and pollution have been brought to our attention, we deem them secondary as decisional factors in a judicial resolution of the issues at hand. So, too, we find it necessary to set aside arguments involving theological and ecclesiastical considerations.

Obviously, there is no topic more closely interwoven with the intimacy of the home and marriage than that which relates to the conception and bearing of progeny. Recent court cases have considered the sanctity of the right to privacy in home, sex and marriage; however, the concept of private rights, with which the state may not interfere in the absence of a compelling state interest, is one of long standing.

As long ago as 1891, in Union Pacific Railway Co. v. Botsford, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891), the court said:

> "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, 'The right to one's person may be said to be a right of complete immunity: to be let alone.'"

In Meyer v. Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923), the United States Supreme Court held that the private right "to marry, establish a home and bring up children" was protected under the fourteenth amendment as an essential liberty. In Prince v. Commonwealth of Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944), the court spoke of the "private realm of family life which the state cannot enter".

In Loving v. Virginia, 388 U.S. 1, 87 S.Ct. 1817, 18 L.Ed.2d 1010 (1967), there was a challenge to the constitutionality of a state statute which purported to restrict marriages solely on the basis of race. While the Supreme Court observed, at page 7, 87 S.Ct. at page 1821, that "marriage is a social relation subject to the State's police power," the court held, at page 12, 87 S.Ct. at page 1824:

> "The Fourteenth Amendment requires that the freedom of choice to marry not be restricted by invidious racial discriminations. Under our Constitution, the freedom to marry or not marry, a person of another race resides with the individual and cannot be infringed by the State."

See also Skinner v. Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942); Farrington v. T. Tokushige, 273 U.S. 284, 47 S.Ct. 406, 71 L.Ed. 646 (1927); Pierce v. Society of the Sisters, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925). See, generally, Warren and Brandeis, "The Right to Privacy," 4 Harv.L.Rev. 193 (1890).

Recent decisions have asserted a judicial application of the ninth amendment

to the matter of privacy in marital relations and contraception. In Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), the court struck down the Connecticut statute which forbade the use of contraceptives. In so doing, the Court noted that the Bill of Rights contains both specific and penumbral guarantees which protect an individual from governmental invasion of the sanctity of his home and the privacies of his life. In the words of the Court, at page 485, 85 S.Ct. at page 1682, many decisions by the Supreme Court "bear witness that the right of privacy which presses for recognition here is a legitimate one." Three of the justices in a concurring opinion stated, at page 491, 85 S.Ct. at page 1685:

> "To hold that a right so basic and fundamental and so deep-rooted in our society as the right of privacy in marriage may be infringed because that right is not guaranteed in so many words by the first eight amendments to the Constitution is to ignore the Ninth Amendment and to give it no effect whatsoever."

In People v. Belous, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), the California supreme court invalidated a state statute which made it illegal to perform an abortion on a woman unless it was necessary to preserve her life. The court said, 80 Cal.Rptr. at page 359, 458 P.2d at page 199:

> "The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a 'right of privacy' or 'liberty' in matters related to marriage, family, and sex."

The *Belous* court pointed out, 80 Cal. Rptr. at page 360, 458 P.2d at page 200, that although this protected area of privacy is not explicitly stated in the Constitution, it is a fundamental liberty that is implicit in the penumbrae of the Bill of Rights, and is supported, by analogy, in many past decisions.

In United States v. Vuitch, 305 F. Supp. 1032, 1035 (D.D.C.1969), the court further observed:

> "There has been, moreover, an increasing indication in decisions of the Supreme Court of the United States that as a secular matter a woman's liberty and right of privacy extends to family, marriage and sex matters and may well include the right to remove an unwanted child at least in early stages of pregnancy."

Although no final decision has as yet been rendered, a three-judge court has been convened in New York in a case involving the same issues under consideration here. Hall v. Lefkowitz, 305 F. Supp. 1030 (S.D.N.Y.1969).

In 2 Loyola University Law Review 1, 8 (April, 1969), former Supreme Court Justice Tom C. Clark concluded from a study of *Griswold* and its predecessor cases:

> "The result of these decisions is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution."

[6] It is clear that in order to justify the regulation of such fundamental private rights, the state must show a compelling need. In Bates v. City of Little Rock, 361 U.S. 516, 524, 80 S.Ct. 412, 417, 4 L.Ed.2d 480 (1960), the Court stated:

> "Where there is a significant encroachment upon personal liberty, the State may prevail only upon showing a subordinating interest which is compelling."

The Supreme Court, in *Griswold*, said, 381 U.S. at page 485, 85 S.Ct. at 1682:

> "The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. And it concerns a law which, in forbidding the *use* of contraceptives rather than

regulating their manufacture or sale, seeks to achieve its goals by means having a maximum destructive impact upon that relationship. Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a 'governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.' NAACP v. Alabama, 377 U.S. 288, 307, 84 S.Ct. 1302, 1314, 12 L.Ed.2d 325."

A comparable viewpoint was set forth by the California supreme court in *Belous*, 80 Cal.Rptr. at page 360, 458 P.2d at page 200, where that court said:

"The critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state * * *."

Similarly, in the case at bar, we must decide whether the state of Wisconsin has a sufficiently compelling interest to justify the broad restriction on a woman's inherently personal right that is contained in § 940.04(1) and (5), Wis. Stats.

[7] The defendants urge that the state's interest in protecting the embryo is a sufficient basis to sustain the statute. Upon a balancing of the relevant interests, we hold that a woman's right to refuse to carry an embryo during the early months of pregnancy may not be invaded by the state without a more compelling public necessity than is reflected in the statute in question. When measured against the claimed "rights" of an embryo of four months or less, we hold that the mother's right transcends that of such an embryo.

We also find no compelling state interest in a need to protect the mother's life. At common law, abortion was not a crime unless the mother was quick with child. People v. Belous, supra, 80 Cal.Rptr. at 358, 458 P.2d at 198. This position was reflected in the original Wisconsin abortion statute, Wis.R.S. 1849, c. 133, §§ 10 and 11, enacted in 1849, which made abortion a punishable offense only if performed upon an unborn quick child. However, in 1858 the abortion statute was revised by elimination of the word "quick," thereby making it an offense to perform an abortion at any time during pregnancy. This change reflected an interest in protecting the life of the mother, for in 1858 any surgical procedure done inside the body was extremely dangerous. Today, many types of surgery, including abortion in the first trimester, are safe and routinely employed medical techniques. People v. Belous, supra, 80 Cal.Rptr. at 360, 458 P.2d at 200. Thus, the result of this court's decision that a mother has the right to determine whether to carry or reject an embryo that has not quickened is a return to the common law definition of abortion; this is not a position without well-established precedent in the common law.

We are persuaded that a medical abortion during early pregnancy is not inherently dangerous to the mother. Nor do we find a compelling state interest in connection with the discouragement of non-marital sexual intercourse. The statute involved does not purport to distinguish between married and unmarried women.

We are invited to resolve the philosophical question, raised in some of the amicus curiae briefs, as to when an embryo becomes a child. For the purposes of this decision, we think it is sufficient to conclude that the mother's interests are superior to that of an unquickened embryo, whether the embryo is mere protoplasm, as the plaintiff contends, or a human being, as the Wisconsin statute declares.

There are a number of situations in which there are especially forceful reasons to support a woman's desire to reject an embryo. These include a rubella or thalidomide pregnancy and one stemming from either rape or incest. The instant statute does not distinguish these special cases, but in our opinion, the state does not have a compelling in-

terest even in the normal situation to require a woman to remain pregnant during the early months following her conception.

[8] Under its police power, the state can regulate certain aspects of abortion. Thus, it is permissible for the state to require that abortions be conducted by qualified physicians. The police power of the state does not, however, entitle it to deny to a woman the basic right reserved to her under the ninth amendment to decide whether she should carry or reject an embryo which has not yet quickened. The challenged sections of the present Wisconsin statute suffer from an infirmity of fatal overbreadth.

V. CONCLUSION

The plaintiff is entitled to a declaratory judgment declaring § 940.04(1) and (5) violative of the United States Constitution. The plaintiff is not entitled to an injunction enjoining the defendants or their successors in office from prosecuting the plaintiff under § 940.-04(1) and (5).

It is so ordered.



Item No. 21

vacated, 402 U.S.___ (1971)



Sidney G. BABBITZ, M.D., Plaintiff,

v.

E. Michael McCANN, District Attorney of Milwaukee County, F. Ryan Duffy, Jr., Judge of the County Court, Milwaukee County, Defendants.

No. 69-C-548.

United States District Court, E. D. Wisconsin.

Nov. 18, 1970.

Proceeding upon order, issued by a three-judge District Court on its own motion, to show cause why prosecutions under a state abortion statute should not be enjoined. Previously the court had adjudged portions of the statute unconstitutional. The Court held that where the court in declaring the abortion statute unconstitutional had hoped that state would forebear from further prosecution thereunder, but the state prosecutor publicly announced in effect that the court's judgment would not deter the state from prosecuting others under the statute and the state even declined to postpone trial of the doctor in question until a possible appeal to the Court of Appeals was determined, "special circumstances" required issuance of an injunction previously denied.

Judgment in accordance with opinion.

1. Courts ⇐405(15)

While motions were pending in Court of Appeals regarding propriety of docketing appeal from three-judge district court, three-judge district court had jurisdiction to grant interlocutory judgment pending such appeal and also to issue permanent injunction, against state court proceedings, to protect and effectuate court's judgment, under statute prohibiting federal court's stay of state court proceedings except where necessary in aid of federal court's jurisdiction or to protect or effectuate its judgments. 28 U.S.C.A. §§ 1253, 2283; Fed.Rules Civ.Proc. rule 62(c), 28 U.S.C.A.

2. Judgment ⇐829(1)

Although decision of three-judge district court declaring state abortion statute unconstitutional was perhaps not literally binding on state, fair application of comity doctrine required state authorities to desist from prosecuting doctor pending appeals which were taken from such declaratory judgment and also to desist from threatening prosecutions of others until such appeals could be resolved.

3. Courts ⇐508(1)

Where protected interests involve freedom of speech or assembly, three-

judge district court is empowered to enjoin any chilling impact upon such First Amendment rights, and Ninth Amendment rights are equally deserving of federal protection. Fed.Rules Civ.Proc. rule 62(c), 28 U.S.C.A.; U.S.C.A.Const. Amends. 1, 9.

4. Courts ⇐508(7)

Where three-judge district court in declaring abortion statute unconstitutional had hoped that state would forebear from further prosecution thereunder, but state prosecutor publicly announced in effect that court's judgment would not deter state from prosecuting others under statute and state even declined to postpone trial of doctor in question until possible appeal to Court of Appeals was determined, "special circumstances" required issuance of injunction previously denied. Fed.Rules Civ. Proc. rule 62(c), 28 U.S.C.A.; 28 U.S. C.A. § 2283; W.S.A.Wis. 940.04(1, 5).

Nathaniel D. Rothstein, Milton R. Bordow and Roy O. Conen, Milwaukee, Wis., Joseph L. Nellis, Washington, D.C., for plaintiff.

Michael Ash, Asst. Dist. Atty., Milwaukee, Wis., for defendants.

Before KERNER, Circuit Judge, and REYNOLDS and GORDON, District Judges.

PER CURIAM.

On October 28, 1970, a hearing was held pursuant to an order to show cause issued by this court on its own motion. At such hearing, arguments were heard on the question of our enjoining the defendants from prosecuting under §§ 940.04(1) and (5), Wis.Stats. Previously, this court had adjudged those portions of the Wisconsin statute unconstitutional. Our decision was filed on March 5, 1970 and is reported in 310 F. Supp. 293 (E.D.Wis.1970). An amended judgment, filed a few days later, on March 11, 1970, provided that the "injunctive relief sought by the plaintiff be and hereby is denied".

Subsequently, the plaintiff commenced another action in this federal district seeking an order restraining the prosecution. On May 11, 1970, as reported in 312 F.Supp. 725 (E.D.Wis.1970), a single-judge district court denied such relief, relying upon the prior analysis of the recent opinion and judgment of this three-judge court.

A direct appeal was taken from the judgment of the three-judge court to the United States Supreme Court, under 28 U.S.C. § 1253, which provides, in part, that "*any party* may appeal to the Supreme Court from an order granting *or denying*" (emphasis added) an injunction by a three-judge district court. That appeal was dismissed by the United States Supreme Court on October 12, 1970, and a few days thereafter this court issued the instant order to show cause.

[1] At the time of the hearing on this order to show cause, an appeal which had been taken from this court's judgment to the court of appeals for the seventh circuit had not as yet been docketed by the latter court; motions regarding the propriety of such docketing were then pending before the court of appeals. The defendants urge that this court does not have jurisdiction to amend its judgment of March 11, 1970, but they concede that we can temporarily restrain the prosecution of Dr. Babbitz under Rule 62(c), Federal Rules of Civil Procedure.

In our opinion, this court not only has jurisdiction to grant an interlocutory judgment pending such appeal, but also has jurisdiction to issue a permanent injunction in order to protect and effectuate the court's judgment under 28 U. S.C. § 2283, which provides:

"§ *2283. Stay of State court proceedings*

A court of the United States may not grant an injunction to stay proceedings in a State court except as expressly authorized by Act of Congress, or where necessary in aid of its juris-

diction, or *to protect or effectuate its judgments.*" (emphasis added)

In American Insurance Company v. Lucas, 38 F.Supp. 926, 932 (W.D.Mo. 1941), it was held that a three-judge court has the power to protect its judgments from imposition. Indeed, we believe that the competence of the court to reconsider its previous order, in the absence of a stay or supersedeas, is one that is inherent in a court. In Illinois Printing Co. v. Electric Shovel Coal Corp., 20 F.Supp. 181, 184 (E.D.Ill. 1937), the court said:

"Every court has power to control, vacate, or correct its own decrees in the interests of justice. It may do so in the furtherance of justice and its power does not depend upon statute but is inherent. Freeman on Judgments, §§ 200 and 220."

We also find authority to re-examine the question of an injunction under 28 U.S.C. § 2202, which provides:

"§ *2202. Further relief*

Further necessary or proper relief based on a declaratory judgment or decree may be granted, after reasonable notice and hearing, against any adverse party whose rights have been determined by such judgment."

In Vermont Structural Slate Co. v. Tatko Bros. Slate Co., 253 F.2d 29, 30 (2d Cir. 1958), the court ruled that although the original declaratory decree did not contain a permanent injunction, such provision could be added later under the court's "residual power".

In our decision of March 5, 1970, we discussed the "impressive authority" which favored forebearance from enjoining pending state prosecutions; with reference to Dr. Babbitz, we indicated our expectation that the state courts would "fully vindicate his federal constitutional rights".

At the hearing in this case held prior to the time that the court filed its decision of March 5, 1970, one of the defendants, Mr. McCann, the district attorney of Milwaukee county, urged us not to issue an injunction. Thereupon, a member of this three-judge court asked him, from the bench, what difference it would make "whether we enjoin you from proceeding or enter a declaratory judgment that the law is unconstitutional? Does it have any practical difference?" The district attorney then responded, in part:

"*Probably not a great deal*, except I would urge upon the Court in a declaratory judgment action, even more than otherwise, the principles of comity and abstention should be considered. * * *" (emphasis added)

The record now before this court demonstrates that our previous forecast regarding the state's response to our judgment has not been met; we find that our declaration and judgment have been completely disregarded by the state authorities. For example, shortly after our decision, the state attorney general issued a statement in a publication entitled "The Prosecutors' Bulletin" in which he asserted that our declaratory judgment "legally affected only the rights of Dr. Babbitz". In effect, this is a public announcement that the judgment of this court will not deter the state from prosecuting others under the statute.

The record before this court also discloses that in a press release dated April 7, 1970, the attorney general stated that the case had been appealed to the United States Supreme Court and that "doctors performing abortions in reliance on *Babbitz* run the risk of prosecution in the event the decision is reversed." The chilling impact of this statement is patently clear.

At the hearing on the present order to show cause, defendants' counsel candidly acknowledged that the district attorney of Milwaukee county and the attorney general of the state of Wisconsin, not only believe that the statute in question is fully constitutional but that they intend to take no other stance until there is a contrary decision by the United States Supreme Court. It thus is unmistakably clear, both from the defend-

ants' conduct and from their counsels' statements, that the Wisconsin prosecutors will steadfastly ignore a declaration of unconstitutionality emanating from either this three-judge district court or from the federal court of appeals.

Because of the state's tacit threats of prosecution, it follows that the general citizenry of Wisconsin will be obliged to disregard our judgment of unconstitutionality. In this sense, we regretfully observe that our hope that the state would "vindicate" the constitutional rights of Dr. Babbitz and others in his position has not been realized. Indeed, the state even declined to postpone the trial of Dr. Babbitz until a possible appeal to the court of appeals was determined. Unless we enjoin this prosecution, the trial of Dr. Babbitz in the state court will commence on November 30, 1970 under a statute which we have declared unconstitutional.

The state's insistence on going forward with the trial of Dr. Babbitz and the prosecutors' tacit threats to the medical profession completely change the context of this case with reference to injunctive relief. We are now in precisely the converse situation to that described in Dombrowski v. Pfister, 380 U.S. 479, 485, 85 S.Ct. 1116, 1120, 14 L.Ed.2d 22 (1965), where the court discussed Murdock v. Pennsylvania, 319 U.S. 105, 63 S.Ct. 870, 87 L.Ed. 1292 (1943):

> "Since injunctive relief looks to the future, and it was not alleged that Pennsylvania courts and prosecutors would fail to respect the *Murdock* ruling, the Court found nothing to justify an injunction."

We now find that there are "special circumstances" as discussed in Cameron v. Johnson, 390 U.S. 611, 618, 88 S.Ct. 1335, 20 L.Ed.2d 182 (1968), and Dombrowski v. Pfister, 380 U.S. 479, 485, 85 S.Ct. 1116, 14 L.Ed.2d 22 (1965), requiring the issuance of an injunction. Upon the present posture of this case, the state authorities have no reasonable expectation of securing a *valid* conviction of Dr. Babbitz.

[2] We are fully aware that our judgment could be reversed upon appeal. We are also mindful that it is arguable that our judgment may not be literally "binding" on the state. See United State ex rel. Lawrence v. Woods, 432 F.2d 1072 (7th Cir. 1970). Nevertheless, we believe that a fair application of the doctrine of comity required the state authorities to desist from prosecuting Dr. Babbitz pending the appeals which were taken in this case and also to desist from threatening prosecutions of others until such appeals could be resolved. In the case at bar, comity has proved to be a one-way street. The continued prosecution of Dr. Babbitz and the admonishments by the state officers meet the language of Cameron v. Johnson, 390 U.S. 611, 621, 88 S.Ct. 1335, 1341, 20 L.Ed2d 182 (1968), where the court said:

> "* * * the statute was enforced against them with no expectation of convictions but only to discourage exercise of protected rights."

[3] It is clear from *Dombrowski* that if the protected interests involve freedom of speech or assembly, this court is empowered to enjoin any chilling impact upon such first amendment rights. We believe that the ninth amendment rights of those involved are equally deserving of federal protection. See Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); NAACP v. Button, 371 U.S. 415, 83 S.Ct. 328, 9 L.Ed.2d 405 (1963). Indeed, it is arguable that the right to privacy of one's person is of even greater stature and magnitude than the meritorious rights included within the first amendment. As noted in *Griswold* (381 U.S. p. 491, 85 S.Ct. 1678), ninth amendment rights are fundamental ones, "deep-rooted in our society".

[4] In enforcing the statute in question, the state authorities are impinging not only on Dr. Babbitz' ninth amendment rights but upon those of the general public.

Unfortunately, it is apparent that the state judiciary has failed to discourage the prosecutors from trespassing on the federal rights in question. The reaction of the state authorities to our judgment relegates our ruling to nothing more than a gratuitous, advisory opinion. Zwickler v. Koota, 389 U.S. 241, 254, 88 S.Ct. 391, 399, 19 L.Ed.2d 444 (1967), places an affirmative duty on this court to weigh a request for a declaratory judgment that a state statute is unconstitutional:

> "We hold that a federal district court has the duty to decide the appropriateness and the merits of the declaratory request irrespective of its conclusion as to the propriety of the issuance of the injunction."

In Romero v. Weakley, 226 F.2d 399, 401 (9th Cir. 1955), the court quoted from Willcox v. Consolidated Gas Co., 212 U.S. 19, 40, 29 S.Ct. 192, 53 L.Ed. 382 (1909), as follows:

> " 'When a Federal court is properly appealed to in a case over which it has by law jurisdiction, it is its duty to take such jurisdiction * * *. The right of a party plaintiff to choose a Federal court where there is a choice cannot be properly denied.' "

The United States Supreme Court does not automatically review the judgments of lower tribunals as a matter of course; the case at bar appears to be a good example of that situation. Nevertheless, the state authorities have taken the position that they will refuse to respect our judgment of unconstitutionality or even that of the court of appeals and will be bound only by a ruling of the United States Supreme Court. Did the United States Supreme Court contemplate on the one hand that a federal three-judge district court *must* declare the constitutionality or unconstitutionality of a state statute and, on the other hand, that the state authorities may wholly dishonor such judgment?

Under all the circumstances of the instant case, we conclude that the only effective way to protect or effectuate our judgment is forthwith to issue an injunction permanently enjoining the pending prosecution of Dr. Babbitz and also permanently enjoining the defendants from henceforth prosecuting others under §§ 940.04(1) and (5), Wis.Stats.

It is ordered that the clerk enter an appropriate judgment.





Amanda HARLING, Petitioner,
v.
DEPARTMENT OF HEALTH AND SOCIAL SERVICES, Respondent.
No. 69-C-560.

United States District Court,
E. D. Wisconsin.
March 11, 1971.

Habeas corpus case by Wisconsin parolee. The District Court, Myron L. Gordon, J., held that a nonphysician's conviction for abortion could not stand in light of federal three-judge District Court ruling declaring Wisconsin abortion statute under which she was convicted to be unconstitutional.

Petition for writ of habeas corpus granted.

1. Habeas Corpus ⇐29

A petition for writ of habeas corpus is a proper means to attack constitutionality of a statute under which a petitioner had been convicted.

2. Abortion ⇐1

A nonphysician's conviction for abortion could not stand in light of federal three-judge district court ruling declaring that Wisconsin abortion statute under which she was convicted is unconstitutional. W.S.A. 940.04(1, 5).

Shellow & Shellow, Milwaukee, Wis., for petitioner.

Robert P. Warren, Atty. Gen. of Wis., by William A. Platz, Asst. Atty. Gen., Madison, for respondent.

DECISION and ORDER

MYRON L. GORDON, District Judge.

The petitioner was convicted by a state court on November 14, 1968, of the commission of an abortion in violation of § 940.04(1), Wis.Stats. (1967). She was sentenced on the same day to a term of three years in the Wisconsin Home for Women at Taycheedah. Her conviction was affirmed by the state supreme court in State v. Harling, 44 Wis.2d 266, 170 N.W.2d 720 (1969). After the present petition for a writ of habeas corpus was filed, Mrs. Harling was released from confinement and now is on parole.

Mrs. Harling's petition initially set forth two rather broad bases which she argued warranted the granting of her application. However, after her petition was filed, and while it still was pending, the case of Babbitz v. McCann, 310 F. Supp. 293 (E.D.Wis.1970), was decided. In *Babbitz*, upon the application of a physician who was undergoing prosecution for the commission of an allegedly illegal abortion, a three-judge district court declared that § 940.04(1) and (5) are unconstitutional.

On the basis of the *Babbitz* ruling, Mrs. Harling submitted a petition for a writ of habeas corpus to the Wisconsin supreme court; such petition was denied on April 13, 1970. Her petition to the federal court for a writ of habeas corpus subsequently was amended and the petitioner now contends that her state conviction on November 14, 1968, is void. It is this contention which will be considered in the present decision.

In an earlier time, it was generally held that a statute which was declared to be unconstitutional was void ab initio. Norton v. Shelby County, 118 U.S. 425, 6 S.Ct. 1121, 30 L.Ed. 178 (1886); Ex parte Siebold, 100 U.S. (10 Otto) 371, 376, 25 L.Ed. 717 (1880). In the latter case, at pages 376–377, the court said:

> "An unconstitutional law is void and is as no law. An offense created by it is not a crime. A conviction under it is not merely erroneous, but is illegal and void, and cannot be a legal cause of imprisonment. It is true, if no writ of error lies, the judgment may be final, in the sense that there may be no means of reversing it. But personal liberty is of so great moment in the eye of the law that the judgment of an inferior court affecting it is not deemed so conclusive but that, as we have seen, the question of the court's authority to try and imprison the party may be reviewed on *habeas corpus*, by a superior court or judge having authority to award the writ. We are satisfied that the present is one of the cases in which this court is authorized to take such jurisdiction. We think so, because, if the laws are unconstitutional and void, the Circuit Court acquired no jurisdiction of the causes. Its authority to indict and try the petitioners arose solely upon these laws."

The breadth of this rule was questioned in several subsequent decisions. See, e. g., Chicot County Drainage District v. Baxter State Bank, 308 U.S. 371, 374, 60 S.Ct. 317, 84 L.Ed. 329 (1940). Cf. Butts v. Merchants & Miners Transportation Co., 230 U.S. 126, 33 S.Ct. 964, 57 L.Ed. 1422 (1913); Campbell v. Sherman, 35 Wis. 103 (1874); Annot., 167 A.L.R. 517 (1947); Crawford, The Legislative Status of an Unconstitutional Statute, 49 Mich.L.Rev. 645, 650 (1951).

This latter group of cases, however, generally does not deal with statutes in-

volving penal liability, and, in my opinion, they do not obviate the problem of whether Mrs. Harling's conviction can stand in light of a ruling declaring the statute under which she was convicted to be unconstitutional.

At no point prior to the time of the *Babbitz* decision did the petitioner raise the question of the constitutionality of § 940.04(1). In addition, it is to be noted that Mrs. Harling is not a physician, unlike the plaintiff in *Babbitz*. These two factors must be considered in resolving the present petition. However, it is clear that Mrs. Harling has exhausted her state remedies, for the supreme court denied her post-*Babbitz* petition for a writ of habeas corpus, concluding that *Babbitz* was not "binding upon this court or controlling."

It is arguable that the doctrine of the *Chicot County* case might preclude the granting of the relief sought in the case at bar. See Note, The Effect of the Unconstitutionality of a Statute, 37 Geo.L.J. 574, 584 (1949), in which the author suggests that Gayes v. New York, 332 U.S. 145, 67 S.Ct. 1711, 91 L.Ed. 1962 (1947), supports the view that if a petitioner has not raised the issue of the unconstitutionality of a statute at his trial, the court can refuse to consider his petition for a writ of habeas corpus. However, the precise scope of *Gayes* has been the subject of some discussion, and I have difficulty in applying it to the present action. Cf. Farnsworth v. United States, 98 U.S.App.D.C. 59, 232 F.2d 59 (1956), and United States v. Moore, 166 F.2d 102 (7th Cir. 1948).

[1, 2] A petition for a writ of habeas corpus is a proper means to attack the constitutionality of a statute under which a petitioner had been convicted. Furthermore, the few cases involving a petitioner who had been convicted under a statute later held to be unconstitutional in another case have generally granted relief by way of discharge upon a writ of habeas corpus. See, e. g., Ex parte Rose, 122 N.J.L. 507, 6 A.2d 389 (Sup.Ct.1939); Ex parte Downing, 7 Cal.App.2d 731, 47 P.2d 322 (Cal.App. 1935); Ex parte Barrett, 25 Okl.Cr. 431, 221 P. 124 (Okla.Crim.App.1923); cf. Desist v. United States, 394 U.S. 244, 261 n. 2, 89 S.Ct. 1030, 22 L.Ed.2d 248 (1969) (dissenting opinion); but see Dowd v. Grazer, 233 Ind. 68, 116 N.E.2d 108 (Ind.1953).

In 1 Sutherland, Statutes and Statutory Construction (Supp.1971 § 111, at 6), the author states:

> "[The] tenderness with which our system regards individual liberty has caused an exception to the rule of estoppel to be made for criminal statutes. Where a statute which declares conduct to be a crime is held unconstitutional, a person who was previously convicted under it may procure his release by habeas corpus."

Babbitz is clear that the state legislature may impose reasonable restrictions on the right of a woman to abort an unquickened fetus. Thus, in 310 F.Supp. at 302, the court stated:

> "Under its police power, the state can regulate certain aspects of abortion. Thus, it is permissible for the state to require that abortions be conducted by qualified physicians."

The declaration in *Babbitz* that § 940.04(1) and (5) are unconstitutional was based upon the premise that the statute is overbroad. On the other hand, rules of severability preclude "saving" a portion of the statute in question so as to accommodate the fact that Mrs. Harling is not a physician or to accommodate a construction that the declaration of unconstitutionality was meant only to extend to Dr. Babbitz or others in his precise position. This conclusion is buttressed by the rules of strict construction generally applied to penal statutes, and they are generally found to be void in their entirety whenever one portion is clearly unconstitutional.

Now, therefore, it is ordered that the petition for a writ of habeas corpus be and hereby is granted. The execution of the writ will be stayed for thirty days to allow the respondent an opportunity to seek appellate court review.

Item No. 23

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

ALFRED L. KENNAN, M.D., ADRIENNE H. CAMPBELL, RITA W. SMIRNOFF, and ANN W. BASHORE, Plaintiffs v. GERALD C. NICHOL, Individually and as District Attorney, Dane County, State of Wisconsin; his agents, assistants, and all those acting in concert or cooperation with him to enforce Wisconsin Statutes 940.04(1) and (5); Defendants	OPINION AND TEMPORARY RESTRAINING ORDER 71-C-118

Plaintiffs attack Sections 940.04(1) and (5) of the Wisconsin Statutes, contending that they violate the Constitution of the United States. Section 940.04(1) provides that any person, other than the mother, who intentionally destroys the life of an unborn child may be punished by fine or imprisonment or both. Section 940.04(5) excepts from the prohibition a "therapeutic abortion," which it defines. For the purposes of subsections (1) and (5), an unborn child is defined as "a human being from the time of conception until it is born alive."

In verified pleadings filed April 26, 1971, plaintiffs Kennan, Smirnoff, and Bashore, allege that on April 19, 1971, at the direction of the defendant district attorney and pursuant to a search warrant issued by a judge of a state court of Wisconsin, police entered the medical offices occupied by plaintiff Kennan in connection with his specialized practice in the performance of abortions, in which office plaintiffs Smirnoff and Bashore were employed as social workers, and that the police seized a number of pieces of equipment and files and records. They allege that on April 19 and 20, the defendant made public statements threatening their imminent arrest under Section 940.04(1). They allege that on April 21, 1971, the defendant caused a criminal prosecution to be in-

itiated against them by causing to be filed in a state court criminal complaints against them alleging violations of Section 940.04(1).

A complaint was filed in this court by the plaintiff Kennan on April 20, 1971, alleging that he was threatened with a criminal prosecution in the state court under the anti-abortion statute and asserting its unconstitutionality under the United States Constitution. On April 20, I entered an order to the defendant district attorney to show cause on April 26 why he should not be restrained from enforcing Section 940.04(1) against Kennan. On April 26, 1971, an amended complaint was filed by plaintiff Kennan, and another plaintiff Campbell, and on April 26, 1971, plaintiffs Smirnoff and Bashore moved for leave to intervene, were granted leave in the absence of objection, and filed a complaint.

In her verified complaint, plaintiff Campbell alleges that she is a married woman living in this district and bearing an unquickened child by her husband, that she and her husband do not wish to have the child, that she was scheduled to have an abortion on May 3, 1971, at the offices of the plaintiff Kennan in the city of Madison in this district, that she cannot afford to go to New York or elsewhere out of state where abortions can be performed legally, and that the criminal prosecution against plaintiff Kennan and the seizure of the medical equipment are preventing her from obtaining the abortion in this district. She undertakes to sue on behalf of a class consisting of members similarly situated.

By affidavit, plaintiff Kennan alleges that the effect of the seizure of the records and equipment in his office is to prevent him from continuing to perform abortions, and that there are over 300 females for whom appointments for the performance of abortions are presently scheduled.

For the purpose of deciding the motion for a temporary restraining order, and for no other purpose, I find the facts to be as I have summarized them above.

In *Babbitz v. McCann*, 310 F. Supp. 293 (E.D. Wis. 1970), a three-judge court consisting of Circuit Judge Kerner and District Judges Reynolds and Gordon, entered judgment declaring that Sections 940.04(1) and (5) violate the Constitution of the United States. My understanding is that this declaratory judgment has not been reversed or modified by any appellate court. In the same

action, the same three-judge court later in 1970 enjoined the district attorney of Milwaukee County and a judge of a county court of Milwaukee County from continuing or initiating prosecutions under Secs. 940.04(1) and (5). 320 F. Supp. 219. On April 19, 1971, the Supreme Court of the United States vacated this injunctive judgment and remanded the case to the three-judge court in the Eastern District of Wisconsin for reconsideration in light of *Younger v. Harris*, 401 U.S. 37 (1971); and *Samuels v. Mackell* and *Fernandez v. Mackell*, 401 U.S. 66 (1971).

In view of the declaratory judgment by the three-judge court in *Babbitz*, and also in view of a similar decision with respect to a similar Illinois statute by a three-judge United States District Court in *Doe v. Scott*, 321 F. Supp. 1385, 1390 (N.D. Ill. 1971), appeal pending, Supreme Court Docket No. 1522, 1523, I conclude that plaintiffs here enjoy a reasonable good chance for ultimate success in this lawsuit on the merits, if it eventuates that a federal three-judge court is free to pass, and does pass, upon the federal constitutional contention.

I find that jurisdiction in this court is present. 28 U.S.C. § 1343(3); 42 U.S.C. § 1983.

The principal question, with respect to the availability of temporary injunctive relief, is whether the plaintiffs have a reasonably good chance ultimately to persuade a federal three-judge court that it should not abstain from acting on the merits of their constitutional claim, and from granting appropriate relief if they prevail on the merits. This question of abstention is rendered unusually difficult by reason of the opinions and orders entered by the Supreme Court of the United States on February 23, 1971, in *Younger v. Harris*, No. 2; *Boyle v. Landry*, No. 4; *Samuels v. Mackell*, Nos. 7 and 9; *Perez v. Ledesma*, No. 60; *Dyson v. Stein*, No. 41; and *Byrne v. Karalexis*, No. 83.

The complaint by plaintiff Kennan was filed in this court on April 20, when he was clearly threatened with a criminal prosecution in the state court but before that prosecution had been commenced. Thus this case presents a situation which was expressly excluded from consideration by the Supreme Court of the United States in its February 23, 1971, decisions. See *Younger v. Harris*, slip opinion at pp. 3-4 and, the concurring opinion by Mr. Justice Brennan in *Perez v. Ledesma*, slip opinion at

p. 25, n. 9. It is contended here by the defendant that this chronological sequence of the commencement of the federal suit and the state court prosecution is too artificial to serve as a basis for determining whether a federal court should abstain. However, from the point of view of those who had sought a federal forum in the cases decided by the Supreme Court of the United States on February 23, 1971, the chronological sequence also appeared to be artificial, but a majority of the Supreme Court was prepared to regard it as decisive in those cases.

Of course, even if a federal court is not otherwise bound to abstain, in order to obtain temporary injunctive relief, a plaintiff must demonstrate that irreparable injury will occur if the relief is denied. Assuming that there is a federal constitutional right vested in a physician to perform abortions upon an unquickened embryo and a federal constitutional right vested in a pregnant woman to decide whether she should carry or reject an unquickened embryo (and I have concluded above that the plaintiffs enjoy a reasonably good chance to prevail in these contentions if the merits are reached by a three-judge federal court), then it clearly follows that to withhold a temporary restraining order is to permit this constitutional right to be lost irreparably with respect to the physician and those women for whom he could otherwise perform the operation in the meantime. For the present, I need not decide, finally, whether the interests of pregnant women can be considered in a suit to which only the physician is a party (only plaintiff Kennan's complaint was filed prior to the commencement of the criminal prosecution in the state court), but should this become a critical issue in this suit, *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965), causes me to conclude that plaintiffs enjoy a reasonable good chance ultimately to prevail in the contention that the physician does enjoy standing to raise the constitutional rights of his patients and potential patients.

For the reasons stated, I conclude that the plaintiffs enjoy a reasonably good chance to prevail in their contention that a three-judge federal court should not abstain in this action,[1] and in their contention that Sections 940.04(1) and (5) violate the Constitution of the United States, and that injunctive relief is necessary to avoid irreparable injury.

Upon the entire record herein, and pursuant to 28 U.S.C. § 2284(3), it is hereby ordered that, until further order of the court:

(1) the defendant, and any and all persons acting in concert with him or at his direction or under his control, are hereby restrained from further enforcement, against the plaintiffs herein, of Sections 940.04(1) and (5), Wisconsin Statutes, in any case involving "an embryo of four months or less" (*Babbitz v. McCann*, 310 F. Supp. 293, 301); and

(2) the defendant, and any and all persons acting in concert with him or at his direction or under his control, are hereby ordered to deliver to the plaintiff Kennan, on or before April 30, 1971, either the originals, or true and complete copies, of all of the documents seized April 19, 1971, which relate to persons who are or may be candidates for abortions on and after that date, and also the two Gomco vacuum pump machines seized April 19, 1971; and

(3) the plaintiffs, and each of them, and all persons acting in concert or cooperation with them, or at their direction, or under their control, are to refrain from destroying or mutilating any of the items, documentary or otherwise, covered by (2), above, unless authorized to do so by further order of the court; and

(4) if the defendant believes that he is unable to comply with the provisions of subparagraph (2), above, he may show cause, on or before April 30, 1971, why he should be relieved of the duty to comply therewith.

ENTERED this 27th day of April, 1971.

BY THE COURT:

/s/ JAMES E. DOYLE
JAMES E. DOYLE
District Judge

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1 I would be strengthened in this view if it appeared that the Supreme Court of Wisconsin had already had the chance to pass upon the federal constitutionality of Section 940.04 (1) and had rejected the challenge. From the incomplete information available to me, it appears that the Supreme Court of Wisconsin has had such an opportunity, *State ex rel. Harling v. Superintendent*, April 13, 1970, but its opinion in that case leaves me uncertain whether the Court intended to reject the constitutional challenge on its merits.

Item No. 24

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

ALFRED L. KENNAN, M.D., Plaintiff v. ROBERT WARREN, Attorney General for the State of Wisconsin; and WISCONSIN STATE MEDICAL EXAMINING BOARD, Defendants	OPINION AND TEMPORARY RESTRAINING ORDER 71-C-132

This action (commenced April 28, 1971) relates to certain facets of a controversy centering upon the alleged operation by the plaintiff and his staff of a medical center in the City of Madison in this district, in which, it is alleged, abortions have been performed in violation of Sections 940.04(1) and (5), and 448.18(1)(a), Wis. Stat.

It appears that there are at least three legal facets of this controversy: (1) a criminal prosecution against Dr. Kennan and certain members of his staff which was commenced on April 21 or April 22, 1971, by the District Attorney of Dane County, Wisconsin, in the County Court for Dane County, charging violations of Sections 940.04(1) and (5); (2) a civil action commenced by the Attorney General of Wisconsin (by the service of a summons and complaint on April 21, 1971) in the Circuit Court for Dane County, Wisconsin, in which the State of Wisconsin is the plaintiff and Dr. Kennan is the defendant (No. 133151 in that court), which action purports to have been brought pursuant to Section 448.19, Wis. Stat., in which it is alleged that Dr. Kennan has repeatedly violated Sections 940.04(1) and 448.18(1)(a), Wis. Stat., and in which judgment is sought permanently enjoining Dr. Kennan and his staff from activity relating to the performance of other than "therapeutic" abortions as defined in Section 940.04(5), Wis. Stat.; and (3) a written warning by the Medical Examining Board of the State of Wisconsin, addressed to Dr. Kennan by the Board on April 27, 1971, that the Board will immediately suspend his license, pursuant to Section 448.18(7), Wis. Stat., unless he ceases to perform abortions "except in strict conformity to the exception to the criminal abortion law

as stated in sec. 940.04(5), Stats., and in strict conformity with accepted medical and surgical standards." I will refer to these three facets herein as "the state court criminal action," "the state court civil injunction action," and "the Medical Board proceeding."

(1) The state court criminal action.

In an action initiated by Dr. Kennan in this court on April 20, 1971, under 42 U.S.C. § 1983 (*Kennan et al., v. Nichol*, W. D. Wis., No. 71-C-118), I entered a temporary restraining order April 27, 1971, pursuant to 28 U.S.C. § 2284(3). I initiated the convening of a three-judge court by the Chief Judge of the Circuit. A three-judge court has been convened by the Chief Judge of the Circuit. It consists of Circuit Judge Kerner, and District Judges Reynolds and Gordon. I have withdrawn from the action, and Judge Gordon is acting as the single United States District Judge for the Western District of Wisconsin in the action, as well as acting as a member of the three-judge court.

The temporary restraining order entered April 27, 1971, enjoined the defendant District Attorney of Dane County, "and any and all persons acting in concert with him or at his direction or under his control" from further enforcement of Sections 940.04(1) and (5), Wis. Stat., against Dr. Kennan and his staff, in any case involving an embryo of four months or less.

At a hearing in this court on May 4, 1971, in the present case (71-C-132), counsel for Dr. Kennan contended that by pursuing the state court civil injunction action, the Attorney General of Wisconsin is "acting in concert" with the District Attorney of Dane County, in violation of the temporary restraining order entered April 27, 1971, in 71-C-118. I permitted counsel for Dr. Kennan to state the contention, and I provided the opportunity for the Assistant Attorney General to respond. However, it is clear that I have no authority to deal with such a contention. If there is a desire to pursue it, it must be directed to the three-judge court which has been convened in 71-C-118, the action in which the temporary restraining order of April 27, 1971, was entered.

(2) The state court civil injunction action.

The complaint by Dr. Kennan against the Attorney General and the Medical Board in this present action, 71-C-132, alleges, among other things, that the Attorney

General, acting as counsel for the Board, has commenced an action in state court to enjoin the operation of Dr. Kennan's clinic. The verified complaint prays for a temporary restraining order restraining the Attorney General and the Board from suspending, revoking or otherwise interfering with Dr. Kennan's license, "or from any other method of further enforcement against [Dr. Kennan] of Sections 940.04(1) and (5) and 448.18, Wis. Stat., in any case involving an embryo of four months or less," and prays for such other relief as the court deems just and proper. I entered an order to show cause on April 28, 1971, in the form submitted by counsel for Dr. Kennan, returnable May 4, 1971, requiring the Attorney General and the Board to show cause why they should not be restrained temporarily from interfering with Dr. Kennan's license, and temporarily "suspending and restraining the operation, enforcement, or execution of Chapter 448 of the Wisconsin Statutes...."

On May 3, 1971, there was filed in this action in this court a verified "amended complaint" in which the defendants (the Attorney General and the Board) remained as they were in the original complaint, but in which a second plaintiff, Adrienne H. Campbell, is shown. Parties may be added to an action only by order of the court. Rule 21, Federal Rules of Civil Procedure. No such order has been sought or entered. Dr. Kennan was free to amend his complaint, without leave of court, since no responsive pleading had been served. Rule 15(a), Federal Rules of Civil Procedure. I treat the amended complaint as an amended complaint by Dr. Kennan, verified by him, and since it is also verified by Adrienne Campbell, I treat it as an affidavit by her, in support of Dr. Kennan's motion for a temporary restraining order. However, Mrs. Campbell is not presently a party to this action.

The amended complaint includes more detailed allegations concerning the history of the state court civil injunction suit, and I will turn to them in a moment. The relief prayed for includes: a temporary restraining order preventing the defendants from interfering with Dr. Kennan's license or from any other method of further enforcement of Sections 940.04(1) and (5) and 448.18(1)(a) against Dr. Kennan, whether civil or criminal, in cases involving an embryo of four months or less; a temporary restraining order preventing the Attorney General from pursuing the state court civil injunction action and from seeking to enforce an order entered by the state court in that action April 30, 1971; the convening of a three-judge court; consolidation in this court of this action (71-C-132) with the earlier action (71-C-118); and permanent declaratory and injunctive judgments.

At the May 4 hearing in this action in this court on the order to show cause with respect to the motion for a temporary restraining order, counsel for the Attorney General and the Board objected to consideration of any temporary relief other than that specifically described in the order to show cause. That is, they contended that the hearing was limited to the Board's warning that Dr. Kennan's license may be suspended, and that it could not reach the matter of the state court civil injunction action. At the time of the hearing I expressed the view that there was merit to this contention, but I permitted argument on the matter of the state court civil injunction action, and provided an opportunity for the Attorney General to present evidence on the point if he so elected. Subsequently, I have concluded that the Attorney General's contention concerning the scope of the May 4 hearing was without merit. This is because I have since ascertained clearly that the state court civil injunction action was commenced pursuant to Section 448.19, Wis. Stat. The temporary relief sought, as stated in the order to show cause, included an order "suspending and restraining the operation, enforcement, or execution of Chapter 448 of the Wisconsin Statutes." The Attorney General and the Board were thus fairly warned that the May 4 hearing would reach the subject of the state court civil injunction action.

From the entire record herein, and by the exercise of judicial notice of the proceedings in the state court civil injunction action and in the earlier action in this court (71-C-118), I make the following findings of fact, for the purpose of acting upon Dr. Kennan's motion for a temporary restraining order, and for no other purpose.

I find that on April 19, 1971, pursuant to a search warrant issued by a judge of a state trial court, and at the direction of the District Attorney of Dane County, police entered the medical offices occupied by Dr. Kennan and his staff, in the city of Madison in this district, in connection with his specialized practice in the performance of abortions, that the police seized equipment and records, and that the practical effect of the seizure was to prevent the continuation of Dr. Kennan's abortion practice for some period of time. On April 19 and 20 the District Attorney made public statements threatening the imminent arrest of Dr. Kennan under Section 940.04(1), Wis. Stat. On April 21 or 22, 1971, the District Attorney commenced a criminal action against Dr. Kennan, alleging violations of Section 940.04(1).

An action (71-C-118) was commenced in this court by Dr. Kennan on April 20, 1971, seeking to enjoin the District Attorney from enforcing Sections 940.04(1) and (5).

On April 21, 1971, expressly pursuant to Section 448.19, Wis. Stat., the Board and the Attorney General commenced, in the name of the state, the state court civil injunction action against Dr. Kennan. No order was entered by the court in that action prior to April 30, 1971.

On April 27, 1971, this court entered a temporary restraining order, pursuant to 28 U.S.C. § 2284(3), preventing the District Attorney and those acting in concert with him, from further enforcement of Sections 940.04(1) and (5) against Dr. Kennan in any case involving an embryo of four months or less. The order was not limited to criminal prosecutions.

Following the issuance of the April 27, 1971, temporary restraining order in this court, in the action commenced here on April 20 by Dr. Kennan against the District Attorney, the Attorney General renewed his application to the court in the state court civil injunction action for an order to show cause and for an ex parte restraining order. On April 30, 1971, the state court entered an order to show cause returnable May 5, 1971, at 3:00 p.m., on the question whether Dr. Kennan should be enjoined from his abortion practice pending the final outcome of the state court action, and an order enjoining Dr. Kennan during the period from April 30, 1971, to May 5.

For reasons stated in some fullness in the opinion I entered in 71-C-118 on April 27, 1971, I conclude that in this present action, 71-C-132, Dr. Kennan enjoys a reasonably good chance of ultimate success in this lawsuit on the merits, if it eventuates that a federal three-judge court is free to pass, and does pass, upon the federal constitutional contention. My April 27 opinion related strictly to Sections 940.04(1) and (5), Wis. Stat. However, I conclude that Sections 448.18(1)(a) and 448.19 depend wholly upon Sections 940.04(1) and (5), since Section 448.18(1)(a) proscribes as "immoral or unprofessional conduct," "procuring, aiding or abetting a criminal abortion" (emphasis added).

With respect to the relief sought in this action in this court concerning the state court civil injunction action, I find that jurisdiction here is present. 28 U.S.C. § 1343(3); 42 U.S.C. § 1983.

Assuming that there is a federal constitutional right vested in a physician to perform abortions upon an unquickened embryo and a federal constitutional right vested in a pregnant woman to decide whether she should carry or reject an unquickened embryo (and I have concluded above that the plaintiff enjoys a reasonably good chance to prevail in these contentions if the merits are reached by a three-judge federal court), then it clearly follows that to withhold a temporary restraining order against state court interference with these rights is to permit them to be lost irreparably with respect to the physician and those women for whom he could otherwise perform the operation in the meantime. For the present, I need not decide, finally, whether the interests of pregnant women can be considered in a suit to which only the physician is a party, but should this become a critical issue in this suit, *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965), causes me to conclude that plaintiffs enjoy a reasonably good chance to prevail in the contention that the physician does enjoy standing to raise the constitutional rights of his patients and potential patients. In accordance with 28 U.S.C. § 2284(3), I specifically find that irreparable damage will result if a state court restraint continues to prevent Dr. Kennan from performing any abortions except in compliance with Sections 940.04(1) and (5), in that time is of the essence for those women for whom Dr. Kennan would otherwise be free to perform abortions and for whom alternative opportunities for this procedure are unavailable, and that the support for this finding and conclusion is to be found in the verified amended complaint.

The principal question with respect to the availability of temporary injunctive relief affecting the state court civil injunction action, is whether the plaintiff has a reasonably good chance ultimately to persuade a federal three-judge court that it should not abstain from acting on the merits of his constitutional claim, and from granting appropriate relief if he prevails on the merits. On this question of abstention, I consider particularly the opinions and orders entered by the Supreme Court of the United States on February 23, 1971, in *Younger v. Harris*, No. 2; *Boyle v. Landry*, No. 4; *Samuels v. Mackell*, Nos. 7 and 9; *Perez v. Ledesma*, No. 60; *Dyson v. Stein*, No. 41; and *Byrne v. Karalexis*, No. 83.

The *Younger* group of cases involved state court prosecutions for alleged violations of criminal statutes and municipal ordinances. Whether the *Younger* doctrine is applicable to a state court civil injunctive action under Section 448.19, Wis. Stat., is a difficult question. However, under the view I take of this situation, this distinction is not critical.

The *Younger* doctrine places heavy emphasis upon whether a state action has actually been commenced prior to the time that the aggrieved party commences an action in the federal district court to vindicate his asserted federal constitutional rights. In the present situation, Dr. Kennan sought a forum here on April 20 (71-C-118). The state court criminal prosecution by the District Attorney was commenced on April 21 or 22, and the state court civil injunction action under Section 448.19 was commenced on April 21. However, in the action commenced by Dr. Kennan in this court on April 20 (71-C-118), only the District Attorney was named as a defendant. Dr. Kennan's present action (71-C-132) against the Attorney General and the Board was not commenced until April 28. The question, in terms of abstention, appears to require an evaluation of this time sequence.

I believe that the specific provisions of Section 448.18(1)(a) and 448.19 are critical to this evaluation. Section 448.18(1)(a) defines "immoral or unprofessional conduct" to include "procuring, aiding or abetting a criminal abortion." Section 448.19 provides that if it appears to the Board upon complaint, or if it is known to the Board, that any person is violating Section 448.18(1)(a) -- or other provisions of Chapter 448 -- the Board or "the district attorney of the proper county may investigate and may, in addition to any other remedies, bring action in the name and on behalf of the state against any such person to enjoin such person from such violation. . . ." Had the District Attorney commenced the state court civil injunctive action against Dr. Kennan on April 21, the *Younger* doctrine would have been inapplicable since Dr. Kennan's action against him (71-C-118) had been filed here April 20. Thus, it must be determined whether *Younger's* heavy emphasis upon the time sequence can be escaped by having the Board, with the Attorney General as its attorney, initiate an action to enjoin Dr. Kennan from "procuring, aiding or abetting a criminal abortion." As I have observed above in another connection, the contention that Dr. Kennan has violated Section 448.18(1)(a) turns on whether the abortions he has performed have been "criminal," and this in turn depends upon whether they were in violation of Sections 940.04(1) and (5), the enforcement of which against Dr. Kennan had been prohibited by the April 27 order.[1]

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[1] I am aware that the complaint in the state court civil injunction action recites that the State Assembly by resolution "authorized" the Attorney

I believe that the *Younger* doctrine should not be amplified to deny a federal forum to an otherwise qualified plaintiff, to assert a federal constitutional challenge to Sections 940.04(1) and (5), solely because his action in the federal court, filed April 20, failed to anticipate every means by which some state or local governmental officer or agency might subsequently attempt to enforce those very statutory provisions against him. I conclude that Dr. Kennan enjoys a reasonably good chance ultimately to persuade a federal three-judge court not to abstain for this reason.

(3) The Medical Board proceeding

With respect to this branch of the present case, I incorporate and reaffirm all of those findings of fact and conclusions of law set forth in part (2) of this opinion, and I add the following findings of fact, solely for the purpose of deciding the motion for a temporary restraining order.

I find that on or about March 29, 1971, the Board decided to initiate an investigative hearing under Section 448.17, at its next regularly scheduled meeting on April 23, 1971, concerning whether Dr. Kennan's activities in operating an abortion clinic were inimical to public health; that such an investigative hearing was held on April 23; that the testimony presented at said hearing persuaded the Board to continue the investigative hearing, and that the Board voted to warn Dr. Kennan; that by letter dated April 27, 1971, the Board did warn Dr. Kennan that it would immediately suspend his license, pursuant to Section 448.18(7), Wis. Stat., unless he ceased "performing abortions except in strict conformity to the exception to the criminal abortion law as stated in 940.04(5), Stats., and in strict conformity with accepted medical and surgical standards"; and that on April 30, 1971, the Board decided that the April 27 warning would continue to stand as issued.

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[1] continued

General to commence it, and that the action was brought pursuant to Section 165.25(1), Wis. Stat., as well as Section 448.19. I note that the resolution "requests" him to "institute proceedings in the appropriate court to obtain an injunction." I note that under Section 165.25(1), when requested by a branch of the legislature, the Attorney General

In accordance with 28 U.S.C. § 2284(3), I specifically find that if the Board is not temporarily restrained from suspending Dr. Kennan's license for a period of not to exceed three months, and a possible like period thereafter, pursuant to Sec. 448.18(7), irreparable injury will result. I find that this irreparable injury consists of that described in part (2) of this opinion, as well as in an inability to practice any kind of medicine during the suspension or suspensions, as well as the damage to Dr. Kennan's reputation and standing. I find support for these findings in the verified amended complaint. I conclude that there is no basis for abstention by a federal district court with respect to the Medical Board proceeding. The *Younger* doctrine is unrelated to state administrative proceedings, as distinguished from state court proceedings. In an action under 42 U.S.C. § 1983, a plaintiff is not required to exhaust either state administrative remedies or state judicial remedies. *Monroe v. Pape*, 365 U.S. 167 (1961); *McNeese v. Board of Education*, 373 U.S. 668 (1963); *Damico v. California*, 389 U.S. 416 (1967).

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[1] continued

shall "appear for the state and prosecute . . . in any court . . . any cause or matter, civil or criminal, in which the state or the people thereof may be in anywise interested." I find nothing in Section 165.25(1) to create any cause of action. Therefore, I consider that the state court civil injunction action must rest solely on Section 448.19. In any event, whether the state court civil injunction action is viewed as having been brought by the Board or independently by the Attorney General, it is an action to enforce Sections 940.04 (1) and (5).

ORDER

Like the temporary restraining order entered April 27, 1971 in 71-C-118, this order is intended to be a temporary restraining order entered pursuant to 28 U.S.C. § 2284(3), and it is to remain in force only until the hearing by a full three-judge court if the Chief Judge of the Circut convenes such a court in response to my notification to him under 28 U.S.C. § 2284(1).

Upon the entire record herein, and pursuant to 28 U.S.C. §2284(3), IT IS HEREBY ORDERED that:

(1) the defendant Attorney General and the defendant Board and the defendant members of said Board, and any and all persons acting in concert with any of them or at the direction of any of them, are restrained from:

(a) further proceedings under Sections 165.25(1), 448.19, 940.04(1), or 940.04(5), Wis. Stat., whether civil or criminal, to enforce against the plaintiff Alfred L. Kennan, the provisions of Sections 940.04(1) and (5) and Section 448.18(1)(a) in any case involving "an embryo of four months or less" *Babbitz v. McCann*, 310 F. Supp. 293, 301 (E.D. Wis. 1970)); and

(b) further proceedings under Sections 448.18 (I)(a) and 448.18(7), Wis. Stat., and any other provision of any statute and Board regulation, to suspend or to revoke the license of plaintiff Kennan to practice medicine and surgery under Section 448.06, Wis. Stat., for the sole reason that he has performed abortions, or intends or threatens to perform abortions, otherwise than in conformity with Section 940.04(5), Wis. Stat., in any case involving "an embryo of four months or less."

IT IS FURTHER ORDERED that at any time prior to the convening of a three-judge court in this action by the Chief Judge of the Circuit, any party hereto may apply to the single judge of this district for an order modifying or amending the terms of this order.

ENTERED this 5th day of May, 1971.

BY THE COURT:

/s/ JAMES E. DOYLE
JAMES E. DOYLE
District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

ALFRED L. KENNAN, M. D., Plaintiff v. ROBERT WARREN, Attorney General for the State of Wisconsin; and WISCONSIN STATE MEDICAL EXAMINING BOARD, Defendants	SUPPLEMENTAL OPINION 71-C-132

This opinion is intended to supplement the opinion I entered herein on May 5, 1971, in conjunction with the entry of a temporary restraining order. It supplements that portion of the May 5 opinion which dealt with the state court civil injunction action by the State of Wisconsin against Dr. Kennan in the Circuit Court for Dane County.

(1)

In *Goss v. State of Illinois*, 321 F.2d 257 (7th Cir. 1963), and *Smith v. Village of Lansing*, 241 F.2d 856(7th Cir. 1957), the Seventh Circuit Court of Appeals held that 42 U.S.C. § 1983 is not an exception to 28 U.S.C. § 2283, a provision which generally prevents a federal court from staying state court proceedings. In my dissent from the majority opinion in *Zwicker v. Boll*, 270 F. Supp. 131 (W.D. Wis. 1967), I expressed the view that intervening decisions of the United States Supreme Court were inconsistent with the earlier Seventh Circuit opinions. This view also has been expressed by the United States District Court of the Northern District of Illinois in *Landry v. Daley*, 288 F. Supp. 200 (N.D. Ill. 1968).

The Court of Appeals for the Seventh Circuit, in one portion of its opinion in *Boyle v. Landry*, 422 F.2d 631 (7th Cir. 1970), appears to reaffirm its holdings in *Goss* and *Smith*, that injunctions to stay proceedings in a state court have not been "expressly authorized" by 42

U.S.C. § 1983. However, if this were the holding in *Boule*, it would follow that in a § 1983 action, 28 U.S.C. § 2283 would constitute an absolute bar to an injunction against proceedings in a state court. I am obliged to conclude that this was not the intended holding in *Boule* because the bulk of the opinion was devoted to a discussion of whether the district court's injunction was "an abuse of discretion" (422 F.2d at 634); whether the district court had made a finding that the state court prosecution was in "bad faith" (*id.*); whether the state court "prosecutions are so great and extensive as to result in a chilling effect on First Amendment rights" "sufficient to justify federal intervention" (*id.*); and whether there had been a showing that any federal question arising in the state court trial would not be adequately disposed of in the state courts or ultimately on review in the United States Supreme Court. *Boule*, therefore, appears to mean that in an appropriate case under § 1983, an injunction against state court proceedings is permissible.

The Supreme Court of the United States has expressly refrained from passing on this question on at least three separate occasions. *Dombrowski v. Pfister*, 380 U.S. 479, 484, n.2 (1965); *Cameron v. Johnson*, 390 U.S. 611, 613, n.3 (1968); *Younger v. Harris* (No. 2, October Term, 1970, February 23, 1971), pp. 16-17 of slip opinion.

For these reasons, as well as those expressed in *Lardru v. Daley*, 288 F. Supp. 200, 224 (N.D. Ill. 1968) and my dissent in *Zwicker v. Boll*, 270 F. Supp. 131, 144-146 (W.D. Wis. 1967), I conclude that a temporary restraining order is permissible in some circumstances, and I conclude further that the circumstances of the present case render such an order appropriate.

(2)

My principal purpose in entering the opinion and order in *Kennan v. Nichol*, 71-C-118, on April 27, 1971, and the opinion and order in *Kennan v. Warren*, 71-C-132, on May 5, 1971, is to prepare the way for a federal three-judge court to consider all of the implications of the state court criminal prosecution of Dr. Kennan, the state court civil injunction action against him, and the Medical Board proceedings in his case, all of which are grounded in the state's criminal statutes on abortion, Sections 940.04(1) and (5). It will be for the three-judge court to determine whether jurisdiction is present; if so, whether it should nevertheless abstain; if it should not abstain, whether plaintiff is entitled to the relief sought.

It is wholly understandable and proper in a situation of this kind that state and local prosecutors and opposing parties and counsel should bring what they consider to be appropriate proceedings in what they consider to be the appropriate judicial forums, and that when such a proceeding is commenced in a state court, the state court should respond as it may feel obliged to respond under the law as it has been determined, or, if the law has not yet been determined, then under the law as the state court believes it should be. I suggest that when a party commences a proceeding in a federal court, it is equally understandable and proper that the federal court should respond as it may feel obliged to respond under the law as it has been determined, or, if the law has not yet been determined, then under the law as the federal court believes it should be.

These questions of the relationships between the state and federal courts have a long and significant history which was most recently the subject of extended and discrepant discussion by various members of the United States Supreme Court in opinions filed February 23, 1971, in *Younger v. Harris*, No. 2, and several related cases. They are profound questions, and their resolution requires a weighing of many competing values.

For the present I undertake to say only that the question of when and under what circumstances the doors of the federal district courts will be open to plaintiffs seeking to vindicate rights claimed to be secured by the federal constitution is a *national* question. When the question is finally answered, the doors of the federal courts will be open or closed, not only to a physician or a pregnant married woman in Madison, Wisconsin, but to blacks in Mississippi, slum dwellers in Harlem, and grape pickers in California. A federal court must not be headstrong. But amenity among state and federal judicial officers must never cause a federal court to close its door to those to whom the door should open.

ENTERED this 6th day of May, 1971.

BY THE COURT:

/s/ James E. Doyle
JAMES E. DOYLE
District Judge

Circuit Judge, held that North Carolina statute, which, with certain statutory exceptions, assigned right to be born to human organism in its early prenatal development as embryo and fetus, did not place unconstitutional burden on fundamental liberty, but that four months' residency requirement for obtaining therapeutic abortion unconstitutionally limited right to travel.

Judgment entered accordingly.

1. Courts ⇐260.4

Class action seeking to have state abortion statute declared unconstitutional and its enforcement enjoined was not proper case in which to apply doctrine of abstention, absent state court interpretation of statute that would alter statute's constitutional impact. G. S.N.C. §§ 14–44 to 14–45.1.

2. Declaratory Judgment ⇐292, 305

County family planning clinic medical director, who was medical expert in obstetrics and contraception and former medical missionary, chairmen of departments of obstetrics and gynecology at teaching hospitals at various universities, and state General Assembly member, who was largely responsible for passage of amendment to state abortion statute, all had standing to bring action seeking to have such statute declared unconstitutional and its enforcement enjoined and could sufficiently represent rights of class whose members they sought to protect. G.S.N.C. §§ 14–44 to 14–45.1.

3. Abortion ⇐1

North Carolina abortion statute, which, with certain statutory exceptions, assigns right to be born to human organism in its early prenatal development as embryo and fetus, does not place unconstitutional burden on fundamental liberty. G.S.N.C. §§ 14–44 to 14–45.1.

4. Constitutional Law ⇐82

Generally women possess fundamental right under Constitution to determine whether they shall bear children before they have become pregnant and state



Elizabeth CORKEY, Charles Hendricks, Roy Parker, Richard Burt and Arthur Jones, Plaintiffs,

v.

Dan K. EDWARDS, Thomas D. Cooper, Jr., Thomas W. Moore, Jr. and Jerry W. Whitley, Defendants.

Civ. No. 2685.

United States District Court, W. D. North Carolina, Charlotte Division.

Argued Nov. 5, 1970.

Decided Feb. 1, 1971.

Class action seeking to have state abortion statute declared unconstitutional and its enforcement enjoined. The Three Judge District Court, Craven,

can interfere with such right of choice only in special circumstances, and may not forbid practice of contraception.

5. Abortion ⇐1
Constitutional Law ⇐83(1)

Four months' residency requirement as condition precedent to obtaining therapeutic abortion under North Carolina abortion statute unconstitutionally limited right to travel. G.S.N.C. § 14-45.1.

6. Abortion ⇐8

Burden of proof, in prosecution for violation of North Carolina abortion statute, is on state to show that abortion did not come within statutory exemptions. G.S.N.C. §§ 14-44 to 14-45.1.

George S. Daly, Jr., Charlotte, N. C., Michael Katz, Evanston, Ill., and Roy Lucas, New York City, for plaintiffs.

James L. Blackburn, Raleigh, N. C., Staff Atty. for Attorney General's Office, and Arnold H. Loewy, Chapel Hill, N. C., for defendants.

Before CRAVEN, Circuit Judge, and JONES and McMILLAN, District Judges.

CRAVEN, Circuit Judge:

This is a class action brought before a three-judge court, 28 U.S.C. § 2281, to have the North Carolina Abortion Statute,[1] G.S. §§ 14-44 to 14-45.1, de-

1. The statute reads:

§ 14-44. Using drugs or instruments to destroy unborn child.—If any person shall wilfully administer to any woman, either pregnant or quick with child, or prescribe for any such woman, or advise or procure any such woman to take any medicine, drug or other substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, he shall be guilty of a felony, and shall be imprisoned in the State's prison for not less than one year nor more than ten years, and be fined at the discretion of the court.

§ 14-45. Using drugs or instruments to produce miscarriage or injure pregnant woman.—If any person shall administer to any pregnant woman, or prescribe for any such woman, or advise and procure such woman to take any medicine, drug or anything whatsoever, with intent thereby to procure the miscarriage of such woman, or to injure or destroy such woman, or shall use any instrument or application for any of the above purposes, he shall be guilty of a felony, and shall be imprisoned in the jail or State's prison for not less than one year nor more than five years and shall be fined, at the discretion of the court.

§ 14-45.1. When abortion not unlawful.—Notwithstanding any of the provisions of G.S. 14-44 and 14-45, it shall not be unlawful to advise, procure, or cause the miscarriage of a pregnant woman or an abortion when the same is performed by a doctor of medicine licensed to practice medicine in North Carolina, if he can reasonably establish that:

There is substantial risk that continuance of the pregnancy would threaten the life or gravely impair the health of the said woman, or

There is substantial risk that the child would be born with grave physical or mental defect, or

The pregnancy resulted from rape or incest and the said alleged rape was reported to a law-enforcement agency or court official within seven days after the alleged rape, and

Only after the said woman has given her written consent for said abortion to be performed, and if the said woman shall be a minor or incompetent as adjudicated by any court of competent jurisdiction then only after permission is given in writing by the parents, or if married, her husband, guardian or person or persons standing in loco parentis to said minor or incompetent, and

Only when the said woman shall have resided in the State of North Carolina for a period of at least four months immediately preceding the operation being performed except in the case of emergency where the life of the said woman is in danger, and

Only if the abortion is performed in a hospital licensed by the North Carolina Medical Care Commission, and

Only after three doctors of medicine not engaged jointly in private practice, one of whom shall be the person performing the abortion, shall have examined said woman and certified in writing the circumstances which they believe to justify the abortion, and

Only when such certificate shall have been submitted before the abortion to the hospital where it is to be performed; provided, however, that where an emergency exists, and the certificate so states, such certificate may be submitted within twenty-four hours after the abortion.

clared unconstitutional and its enforcement enjoined.

Although the law is no respecter of persons, plaintiffs' very occupations lend credence to their contention that the state may not constitutionally prevent or circumscribe the fundamental right of a woman to choose whether or not to bear children and to prevent it by abortion if she and her physician should decide to do so.

Dr. Elizabeth Corkey is the Medical Director of the Mecklenburg County Family Planning Clinic, a medical expert in obstetrics and contraception, and formerly a medical missionary. Plaintiffs Hendrix, Parker and Burt are also doctors of medicine and respectively the Chairmen of the Departments of Obstetrics and Gynecology at the teaching hospitals of the University of North Carolina, Duke University and Wake Forest University. Each is a registered and licensed physician and surgeon under North Carolina law and each is certified as a specialist in the field of obstetrics and gynecology. Plaintiff Jones is a member of the North Carolina General Assembly and was largely responsible for the passage of the 1967 amendment to the statutes challenged in this law suit. For many years he has been an interested student of contraception, abortion and family planning. It is interesting that he asks the court to invalidate a statute for which he is largely responsible. His position is that it is the least restrictive legislation he could get enacted but that even so it is an unconstitutional burden on fundamental liberty.

Unquestionably, every one of the five plaintiffs is a qualified and informed expert on the problem of abortion in North Carolina. Indeed, each of them is doubtless qualified to testify as an expert witness in this very case. Although we deeply respect their informed opinions that the state has no justifiable interest in interfering with a woman's fundamental right to choose whether or not to bear children and implementing that right by choosing to abort, we think such a conclusion necessarily involves a value judgment we may not properly make. It seems to us the legislature may not unreasonably conclude that there is a sufficient public interest in protecting the embryo to permit limited statutory intrusion into what would otherwise be a protected zone of privacy. In only one minor respect do we hold the statute unconstitutional: the residency requirement as a condition precedent to obtaining a therapeutic abortion unconstitutionally, we think, limits the right to travel.

We avoid another serious constitutional problem by interpretation. We think the legislature did not intend to reverse the presumption of innocence, and that the burden of proof in a prosecution is on the state to show that an abortion did not come within the exemptions of G.S. § 14-45.1.

[1, 2] Despite the several assertions made by the state concerning matters of jurisdiction, we decline to dismiss on these grounds. The issues have been exhausted in other actions considering abortion laws, and we therefore deal with them summarily. First, we find that this is not a proper case in which to apply the doctrine of abstention, there being no state court interpretation of the statute that would alter the statute's constitutional impact. Zwickler v. Koota, 389 U.S. 241, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967); Doe v. Randall, 314 F.Supp. 32 (D.Minn.1970). Nor do we accept the argument that justiciability fails for lack of standing. Flast v. Cohen, 392 U.S. 83, 88 S.Ct. 1942, 20 L.Ed.2d 947 (1968); Roe v. Wade, 314 F.Supp. 1217, 1220 (N.D.Tex.1970); see Berger, Standing to Sue in Public Actions, Is It a Constitutional Requirement? 78 Yale L.J. 816 (1969). Finally, we agree that the plaintiffs are able to represent the rights of the class whose members they seek to protect. See Griswold v. Connecticut, 381 U.S. 479, 481, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); Roe v. Wade, *supra*, 314 F.Supp. at 1219-1220.

I.

[3, 4] There is nothing in the United States Constitution about birth, contraception or abortion. But in Griswold v. Connecticut, *supra*, the Supreme Court derived from the several amendments to the Constitution a right of privacy. We are urged to extend Griswold v. Connecticut, *supra*, and its zone of privacy to insulate abortion from legislative control. In *Griswold* the Supreme Court recognized a zone of marital privacy into which the state may not constitutionally intrude where its only interest in doing so was said to be the discouragement of extramarital sexual relations. Thus, the court struck down Connecticut's law forbidding the giving of information and instruction and advice to married persons as to the means of preventing conception.

We agree with plaintiffs that there is no more precious aspect of the concept of liberty than the right to be left alone. As Mr. Justice Brandeis said dissenting in Olmstead v. United States, 277 U.S. 438, 478, 48 S.Ct. 564, 572, 72 L.Ed. 944 (1928):

> The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings, and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men.

Even earlier, in Union Pacific Railway Company v. Botsford, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 36 L.Ed. 734 (1891), the Court said:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint and interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, 'The right to one's person may be said to be a right of complete immunity: to be let alone'.

We also agree with plaintiffs that whether or not to bear a child is ordinarily and up to a point within the zone of privacy of a woman and that she has the right to be let alone in making that determination. In short, it is none of the state's business whether a woman chooses to become pregnant, and beyond its province to forbid the practice of contraception. Griswold v. Connecticut, *supra*.

But that is not quite the question in this case. We think it is this: Can the State of North Carolina constitutionally assign to the human organism in its early prenatal development as embryo and fetus the right to be born (with certain exceptions as set out in the statute)? We think the answer must be "yes".

For the purposes of this case we assume, if we are not required to recognize, *e. g.*, Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678 (1965); Baird v. Eisenstadt, 1 Cir., 1970, 429 F.2d 1398, that as a general matter women possess under our Constitution a "fundamental right" to determine whether they shall bear children before they have become pregnant. A state may interfere with this right of choice only in special circumstances. *E. g.*, Buck v. Bell, 274 U.S. 200, 47 S.Ct. 584, 71 L.Ed. 1000 (1927). We deal in this case, however, not merely with whether a woman has a generalized right to choose whether to bear children, but instead with the more complicated question whether a pregnant woman has the right to cause the abortion of the embryo or fetus she carries in her womb. We do not find that an equation of the generalized right of the woman to determine whether she shall bear children with the asserted right to abort an embryo or fetus is compelled by fact or logic. Exercise of the right to an abortion on request is not essential to

an effective exercise of the right not to bear a child, if a child for whatever reason is not wanted. Abstinence, rhythm, contraception and sterilization are alternative means to this end. The first is, of course, infallible; the latter three are reliable to varying degrees approaching certainty. Before the "moment" of conception has occurred, *see generally* Ziff, Recent Abortion Law Reforms (Or Much Ado About Nothing), 60 J.Crim. L.C. & P.S. 3, 20–21 (1969), the choice whether or not to bear children is made in circumstances quite different from those in which such a choice might be made after conception. Apart, the sperm and the unfertilized egg will die; neither has the capacity to grow and develop, independently as does the fertilized egg. During fertilization, sperm and egg pool their nucleii and chromosomes. Biologically, a living organism belonging to the species homo sapiens is created out of this organization. Genetically, the adult man was from such a beginning all that he essentially has become in every cell and human attribute. *See generally* Gray, Anatomy of the Human Body 21–60 (Goss 27th ed. 1959); 5 Lawyers' Medical Cyclopedia § 37.1 (1960). The basic distinction between a decision whether to bear children which is made before conception and one which is made after conception is that the first contemplates the creation of a new human organism, but the latter contemplates the destruction of such an organism already created. To some engaged in the controversy over abortion, this distinction is one without a difference. These men of intelligence and good will do not perceive the human organism in the early part of its life cycle as a human "being" or "person". In their view, the granting to such an organism of the right to survive on a basis of equality with human beings generally should be delayed until a later stage in its development. To others, however, the "moment" of conception or some stage of development very close to this "moment" is the point at which distinctively human life begins. In their view, the difference between the decision not to conceive and the decision to abort is of fundamental, determinative importance. Thus the root problem in the controversy over abortion is the one of assigning value to embryonic and fetal life. *See* Giannella, The Difficult Quest for a Truly Humane Abortion Law, 13 Vill.L.Rev. 257 (1968).

"In considering the problem of valuing prenatal life, we heed the words of Mr. Justice Holmes:

> 'It is a misfortune if a judge reads his conscious or unconscious sympathy with one side or the other prematurely into the law, and forgets that what seem to him to be first principles are believed by half his fellow men to be wrong * * *.'

Holmes, Collected Legal Papers 295 (1920). When distinctively human life begins is a matter about which reasonable, fair-minded men are in basic disagreement. Thus this case does not concern simply whether the pregnant woman has a fundamental right to be let alone in the control of her body processes, *cf.* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 11 S.Ct. 1000, 35 L. Ed. 734 (1891) (submission to surgical examination), for it is unresolved whether, in the common understanding of the society in which she lives, choice of the destiny of the human organism developing within her is a matter directly affecting only her individual rights." Rosen v. Louisiana State Board of Medical Examiners, 318 F.Supp. 1217, 1224 (E.D.La.1970) (footnotes omitted).

Our inquiry must focus on the nature and extent of the state interest necessary to justify an invasion of the fundamental right of privacy. We are mindful of Holmes' admonition in his now vindicated[2] dissent in Lochner v. State

2. *See, e. g.*, Williamson v. Lee Optical of Oklahoma, 348 U.S. 483, 75 S.Ct. 461, 99 L.Ed. 563 (1955); Giboney v. Empire Storage and Ice Company, 336 U.S. 490, 69 S.Ct. 684, 93 L.Ed. 834 (1949); Lincoln Federal Labor Union

of New York, 198 U.S. 45, 74, 25 S.Ct. 539, 49 L.Ed. 937 (1905), that the Constitution "is made for people of fundamentally differing views, and the accident of our finding certain opinions natural and familiar, or novel, and even shocking, ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States." 198 U.S. at 76, 25 S.Ct. at 547.

The concept of state interest is one that has evaded specific definition.[3]

> An attempt to define its reach or trace its outer limits is fruitless, for each case must turn on its own facts. The definition is essentially the product of legislative determination addressed to the purposes of government, purposes neither abstractly nor historically capable of complete definition. Subject to specific constitutional limitations, when the legislature has spoken, the public interest has been declared in terms well-nigh conclusive.
>
> * * * * * *
>
> Public safety, public health, morality, peace and quiet, law and order—these are some of the more conspicuous examples of the traditional application of the police power to municipal affairs. Yet they merely illustrate the scope of the power and do not delimit it.

Berman v. Parker, 348 U.S. 26, 32, 75 S.Ct. 98, 99 L.Ed. 27 (1954).

To determine the state interest we shall not attempt to choose between extreme positions. Whether possessing a soul from the moment of conception or mere protoplasm, the fertilized egg is, we think, "unique as a physical entity," Lucas, Federal Constitutional Limitations of the Enforcement and Administration of State Abortion Statutes, 46 N.C.L.Rev. 730, 744 (1968), with the potential to become a person. Whatever that entity is, the state has chosen to protect its very existence. The state's power to protect children is a well established constitutional maxim. See, Shelton v. Tucker, 364 U.S. 479, 485, 81 S.Ct. 247, 5 L.Ed.2d 231 (1960); Prince v. Massachusetts, 321 U.S. 158, at 166–168, 64 S.Ct. 438, 88 L.Ed. 645. That this power should be used to protect a fertilized egg or embryo or fetus during the period of gestation embodies no logical infirmity, but would seemingly fall within the "plenary power of government." Poe v. Ullman, 367 U.S. 497, at 539, 81 S.Ct. 1752, 6 L.Ed.2d 989 (Harlan, J., dissenting). That there is a state interest has until recently been taken for granted. History sides with the state.[4]

In Babbitz v. McCann, 310 F.Supp. 293 (E.D.Wis.1970), a three-judge court sitting in judgment of Wisconsin's abortion law recognized the interest of the unborn child as well as that of the mother. That court chose to weigh the two: "For the purposes of this decision, we think it is sufficient to conclude that the mother's interests [before quickening] are superior to that of an unquickened embryo, * * *" *Id.* at 301. See also, Roe v. Wade, 314 F.Supp. 1217 (N.D.Tex.1970). Striking such a balance is not unreasonable. It may, indeed, be wide, humane and enlightened, but we

No. 19129 A.F. of L. v. Northwestern Iron & Metal Company, 335 U.S. 525, 69 S.Ct. 251, 93 L.Ed. 212 (1949); Olsen v. Nebraska, 313 U.S. 236, 61 S.Ct. 862, 85 L.Ed. 1305 (1941); West Coast Hotel Co. v. Parrish, 300 U.S. 379, 57 S.Ct. 578, 81 L.Ed. 703 (1937).

3. *See, e. g.*, United States v. O'Brien, 391 U.S. 367, 88 S.Ct. 1673, 20 L.Ed.2d 672 (1968).

4. Under the common law in England, and in the early periods of this country's existence, it was a crime to commit acts leading to an abortion only after "quickening", but the scope of the prohibited period was extended to cover the entire time from conception to natural birth by statute in this country beginning in the latter part of the nineteenth century. Lucas, Federal Constitutional Limitations on the Enforcement and Administration of State Abortion Statutes, 46 N.C.L.Rev. 730, 731–35 (1968). The North Carolina statute in question was enacted in its original form in 1881 and thereafter not amended until 1967.

submit it is a value judgment not committed to the discretion of judges but reposing instead in the representative branch of government. Although there is a difference between social due process and the discredited economic due process of *Lochner*, *supra*, there is, we think, no real distinction. Both involve values. As Mr. Justice Frankfurter wrote:

> Courts can fulfill their responsibility in a democratic society only to the extent that they succeed in shaping their judgments by rational standards, and rational standards are both impersonal and communicable. Matters of policy, however, are by definition matters which demand the resolution of conflicts of value, and the elements of conflicting values are largely imponderable. Assessment of their competing worth involves differences of feeling; it is also an exercise in prophesy. Obviously the proper forum for mediating a clash of feelings and rendering a prophetic judgment is the body chosen for those purposes by the people.

American Federation of Labor v. American Sash & Door Co., 335 U.S. 538, 557, 69 S.Ct. 258, 267, 93 L.Ed. 222 (1949).

Persuasive, therefore, as the host of statistics, facts and opinions plaintiffs urge upon us appear to be, and as commendable as the efforts plaintiffs have shown in their attempt to right what is considered by many a social wrong are, we must decline what we consider to be an invitation to decide what is best for North Carolina.[5] The legislature is the proper arena for the resolution of "fundamentally differing views." [6]

II.

[5] The plaintiffs also challenge the constitutionality of the residency requirement contained in G.S. § 14–45.1 limiting the availability of therapeutic abortions to those women who have "resided in the State of North Carolina for a period of at least four months immediately preceding the operation being performed except in the case of emergency where the life of the said woman is in danger." The basis of the attack on the constitutionality of this provision is that it unduly infringes upon the fundamental right to travel guaranteed to all citizens. Shapiro v. Thompson, 394 U.S. 618, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1968); United States v. Guest, 383 U.S. 745, 86 S.Ct. 1170, 16 L.Ed.2d 239 (1966). See also, Keenan v. Board of Law Examiners of State of North Carolina, 317 F.Supp. 1350 (E.D.N.C.1970).

The state expresses a fear that has not materialized; taxation of our hospital facilities by an influx of out of state patients seeking abortions. We think our law is not so liberal. But if any protection is needed, the sweep of the provisions in 14–45.1 far exceeds the scope of the interest by penalizing those who enter North Carolina with the bona fide intent of making the state their permanent residence. "[T]he effect of the waiting-period requirement * * * is to create two classes * * * indistinguishable from each other except that one is composed of residents * * *." Shapiro v. Thompson, *supra*, at 627, 89 S.Ct. at 1327.

We conclude that the requirement is overbroad. The interest of the state in maintenance of quality medical treatment for its citizens can be effected without such unnecessary discrimination against other citizens of the United States. In the unlikely event medical facilities should become overtaxed, some fair system of priority, short of flat

5. Since the state's interest in the protection of the embryo is sufficient to support the legislation, we need not consider the interest in protecting the mother's health except to say we think that interest is exhausted with the sensible requirement that no unlicensed practitioner may perform an abortion. Apparently, abortions by competent medical doctors within the first three months are no more dangerous to life and health than live births. *See*, People v. Belous, 80 Cal.Rptr. 354, 362, 458 P.2d 194, 200–201 (1969).

6. Holmes, J., dissenting in Lochner, *supra*, at 74, 25 S.Ct. 539.

exclusion of non-residents, may be devised.

III.

[6] G.S. § 14–44 makes it a felony to willfully administer to any woman who is pregnant or quick with child any substance whatever with intent to destroy *such child*. G.S. § 14–45 is virtually identical but the evil intent proscribed is to procure a miscarriage or injure or destroy *the woman*. The thrust of 14–44 is to protect the unborn child and the thrust of 14–45 to protect the pregnant woman.

G.S. § 14–45.1, enacted in 1967, provides that G.S. §§ 14–44 and 14–45 do not apply when an abortion is performed by a doctor of medicine, licensed in North Carolina, "if he can reasonably establish that":

(1) There is substantial risk that continuation of the pregnancy would threaten the life or gravely impair the health of the woman or;

(2) substantial risk the child would be born with grave physical or mental defect or;

(3) the pregnancy resulted from rape or incest.

The foregoing are the three reasons that will suffice under North Carolina law to make abortion lawful. The rest of 14–45.1 establishes certain procedures that must be followed:

(1) the woman, or if she is a minor or incompetent, someone acting for her, must give her written consent to the abortion;

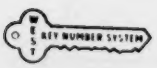
(2) the abortion must be performed in a hospital licensed by the North Carolina Medical Care Commission;

(3) three doctors must have certified in writing the circumstances they believe to justify the abortion and the certificate furnished to the hospital. There is a provision that in an emergency the certificate may be submitted to the hospital within 24 hours after the abortion.

Although we may not interpret a state statute with finality, for that is the province of North Carolina's highest court, we think the words in G.S. § 14–45.1 authorizing abortion by a medical doctor "* * * if he can reasonably establish that * * *" simply means that the doctor must establish *to his own satisfaction* that one of the three statutory reasons for abortion exists before he may lawfully proceed. We would not lightly assume that the legislature meant to make all abortions unlawful unless in a criminal prosecution the medical doctor could reasonably establish his innocence. The presumption of innocence is deeply rooted in our fundamental law. To read the statute so as to place the burden of proof upon the defendant in a criminal prosecution would offend a maxim implicit in due process—that the accused is presumed innocent until proven guilty. Coffin v. United States, 156 U.S. 432, 453–460, 15 S.Ct. 394, 39 L.Ed. 481 (1895). See also, United States v. Vuitch, 305 F. Supp. 1032, 1034 (D.D.C.1969). The burden of proof must be upon the state to show that the conditions for performing therapeutic abortions, a substantial risk to the life or the health of the mother, or a substantial risk that the child would be born with grave physical or mental defect, or rape or incest, were not present. Due process forbids that the accused be required to establish to the court and jury that the abortion performed came within the exemptions of the statute.

We think this was unquestionably the legislative intent, and since the statute can be saved only by such an interpretation, we do not hesitate to put that construction upon it.

An appropriate judgment will be entered declaring the statutes constitutional except for the residency requirement.



A. H. STEINBERG, M.D. and R. Vance Fitzgerald, M.D. and Sandra Frank and Waldemar Agrow and Mary Doe, for and on behalf of all persons similarly situated, Plaintiffs,

v.

Paul BROWN, Att'y General of Ohio, Defendants, and Harry Friberg, Prosecuting Att'y of Lucas County, Ohio, and Anthony Bosch, Chief of Police, Toledo, and Intervening Defendant Homer Schroeder, M.D.

No. C 70-289.

United States District Court,
N. D. Ohio, W. D.
Dec. 18, 1970.

Action for injunctive and declaratory relief, attacking validity of Ohio abortion statute. The three-judge Dis-

trict Court, Don J. Young, J., held that the statute is not unconstitutionally vague and does not violate protected right of privacy, the equal protection clause, or the cruel and unusual punishment prohibition.

Judgment for defendants.

Ben C. Green, J., dissented and filed opinion.

1. Constitutional Law ⇐42

Plaintiffs, including physicians, social worker, clergyman, and mother who had been pregnant at time of commencement of action, had standing to challenge constitutionality of Ohio abortion statute. R.C.Ohio § 2901.16.

2. Courts ⇐508(7)

Plaintiffs attacking constitutionality of Ohio abortion statute were not entitled to injunction against enforcement of statute where it did not appear that prosecution of any plaintiff was commenced or even threatened.

3. Criminal Law ⇐13

Ohio abortion statute is not unconstitutionally vague. R.C.Ohio § 2901.16.

4. Abortion ⇐1
Constitutional Law ⇐82

Ohio abortion statute does not deprive persons of privacy protected by Federal Constitution. R.C.Ohio § 2901.16; U.S.C.A.Const. Amends. 1, 5, 14.

5. Abortion ⇐1

State has legitimate interest to legislate for purpose of affording embryonic or fetal organism an opportunity to survive, and this interest is superior to claimed right of pregnant woman or anyone else to destroy fetus except when necessary to preserve her own life. R.C.Ohio § 2901.16.

6. Constitutional Law ⇐82

Right and power of man or woman to determine whether or not to participate in process of creation is private and personal one with which law cannot and should not interfere.

7. Abortion ⇐1
Constitutional Law ⇐250

Ohio abortion statute does not violate equal protection clause, despite claim that under it wealthy persons are better able to procure abortions than the poor. R.C.Ohio § 2901.16; U.S.C.A. Const. Amend. 14.

8. Constitutional Law ⇐211

Equal protection clause is not designed to prevent that inequality which is often found in life and nature. U.S.C.A.Const. Amend. 14.

9. Criminal Law ⇐1213

Ohio abortion statute does not violate Eighth Amendment proscription of cruel and unusual punishment. R.C.Ohio § 2901.16; U.S.C.A.Const. Amend. 8.

Gerald B. Lackey, Harland M. Britz, Louise Jacobson, Toledo, Ohio, for plaintiffs.

Wm. J. Lee, Asst. Atty. Gen., Columbus, Ohio, for Paul Brown.

John Hayward, Toledo, Ohio, for Harry Friberg.

Frank Pizza, Toledo, Ohio, for Anthony Bosch.

David J. Young, Columbus, Ohio, for Homer Schroeder.

Before WEICK, Circuit Judge, GREEN and YOUNG, District Judges.

OPINION

DON J. YOUNG, District Judge.

This is another in a series of cases which have been and are being filed in various courts throughout the United States attacking the constitutionality of state statutes forbidding abortions. This particular action was brought under Title 28 U.S.C. §§ 1331-1343, Title 28 U.S.C. §§ 2201 and 2202, Title 28 U.S.C. §§ 2281 and 2284, and Title 42 U.S.C. § 1983. The plaintiffs seek a declaratory judgment that Ohio's abortion statute, Section 2901.16 Ohio Rev.

Code,[1] is unconstitutional under the First, Fourth, Fifth, Eighth, Ninth, and Fourteenth Amendments to the Constitution of the United States. They also seek injunctive relief against the enforcement of the statute. Hence a three judge court was convened to hear and determine the matter.

The plaintiffs claim that each of them represents a class of persons who are affected by the Ohio statute complained of. One plaintiff is a physician specializing in obstetrics and gynecology; one is a psychiatrist; one is a social worker; one is a minister of religion; and the final one is a young woman, married but separated from her husband, the mother of one child born in wedlock, and at the time of commencement of the action early in September, 1970, eight to ten weeks pregnant with another child conceived in wedlock.

The defendants named in the amended complaint are the Governor and Attorney General of the State of Ohio, the Prosecuting Attorney of Lucas County, Ohio, wherein this Division of the District Court sits, and the Chief of Police of the City of Toledo, the county seat of Lucas County.

The amended complaint seeks a declaratory judgment that Section 2901.16 Ohio Rev.Code is in violation of the rights of the plaintiffs under the six amendments to the Constitution listed above and for injunctive relief.

A motion for a temporary restraining order was heard and overruled by the single judge of the Western Division of the Northern District of Ohio, and a motion to intervene as a party defendant on behalf of the unborn child of the plaintiff Mary Doe, and the class of unborn children of the women of the class represented by Mary Doe, filed by Homer Schroeder, M. D. was granted by this single judge.

Dr. Schroeder also filed a motion to be appointed as Guardian ad Litem for the unborn child, and motions for leave to file briefs *amicus curiae* were filed by a group of some forty organizations and individuals supporting the plaintiffs, and by the Ohio Right to Life Society, Inc. supporting the defendants. Various other motions were filed, including motions by all of the defendants except the intervening defendant Schroeder to dismiss the complaint, and a motion of the plaintiff to dismiss the intervening defendant Schroeder.

The motions to dismiss were overruled, as were the motion to appoint a guardian ad litem for the unborn child and children, and the other technical motions. The two principal motions for leave to file briefs *amicus curiae* were granted.

The case was submitted upon the evidence offered at the hearing on the motion for a temporary restraining order, certain stipulations, the deposition of John F. Hillabrand, M. D., the briefs, and arguments of counsel.

The evidence indicated that the plaintiffs Steinberg and Fitzgerald had been consulted by the plaintiff Mary Doe. When Dr. Steinberg examined her on October second, she appeared to be eight to ten weeks pregnant, but he testified that another doctor might think she was twelve to fourteen weeks pregnant. He also testified that she was in normal physical condition, and that her previ-

1. Ohio's abortion statute provides:

> No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose.
>
> Whoever violates this section, if the woman either miscarries or dies in consequence thereof, shall be imprisoned not less than one nor more than seven years.

This statute or one very similar to it has been in effect since at least 1834. Section 1 of the Act of February 7, 1834, S & C Stat. 440. Wilson v. State, 2 Ohio St. 319 (1853). There have been many prosecutions under it but until the present case, so far as we have been able to ascertain, no one has ever challenged its constitutionality.

ous pregnancy had been normal, with no complications. He further testified that at that stage of her pregnancy, abortion would present less hazard to life than to carry the child to term, but this situation would not continue, as the hazards of abortion increase later in pregnancy.

The plaintiff psychiatrist, Dr. Fitzgerald, testified that Mary Doe had a serious defect in her ability to make judgments about people and situations; that her daydreams influenced her more than the actual facts; that she was moderately depressed and withdrawn; that she was seriously disturbed, and presented gross or serious defects in her ego-functioning; that she could become a child-battering mother; and that she irrationally rejected the alternative to abortion of carrying the child to term and then consenting to adoptive placement. However, he did not predict that she would either die or kill herself if this pregnancy were carried to term, although it would do her grave psychological harm. He stated that the likelihood of great damage coming to the infant from neglect or abuse were high indeed. It was his conclusion that in such states as California or Colorado, Mary Doe could receive therapeutic approval for abortion on psychiatric and medical grounds.

The evidence revealed that Mary Doe was a welfare recipient in Wood County, Ohio, adjacent to Lucas County. She is twenty-one years old.

Both of the plaintiff doctors testified that they believed they would be violating the Ohio abortion statute if they advised the plaintiff Mary Doe to seek an abortion outside the State of Ohio, although it was stipulated in evidence that no physician had ever been prosecuted in Lucas County for a violation of Section 2901.16 Ohio Rev.Code as an aider and abettor on the ground that he counselled or procured an abortion, nor had any minister or social worker. It was also stipulated that no such prosecutions had ever been threatened, nor had any of the plaintiffs ever been warned by any law enforcement authorities.

The only other evidence in the case was the deposition of Dr. Hillabrand offered by the defendants. This concerned the development of unborn children from conception to birth. It also offered statistical evidence that the risk of maternal mortality was far higher from abortions performed even under clinical conditions than from carrying the child until natural childbirth. This testimony is, of course, in square conflict with that of the plaintiff Steinberg, but it is unnecessary for the purposes of this opinion to resolve this conflict, since it involves policy considerations which are properly legislative, rather than judicial, concerns.

This case presents threshold questions of the right to injunctive relief, standing of the plaintiffs to maintain the action, and the doctrine of abstention. These problems have been considered in other similar cases.

[1] The question of standing is considered in Roe v. Wade, 314 F.Supp. 1217 (N.D.Texas 1970), and Doe v. Bolton, 319 F.Supp. 1048 (N.D.Georgia 1970). Both cases resolved the question favorably to parties who stood in the positions of the plaintiffs here. We accept the conclusions in these cases, and hold that the plaintiffs herein have proper standing to maintain this action. *Cf.* Flast v. Cohen, 392 U.S. 83, 88 S.Ct. 1942, 20 L.Ed.2d 947 (1968).

[2] The problem of abstention was considered and abstention denied in the case of Babbitz v. McCann, 310 F.Supp. 293 (E.D.Wis.1970) app. dis. 400 U.S. 1, 91 S.Ct. 12, 27 L.Ed.2d 1 (1970). See also, Doe v. Bolton, *supra*. There was no proof that prosecution of any of the plaintiffs was commenced or even threatened. Plaintiffs are therefore not entitled to injunctive relief. The prayer for injunction restraining the enforcement of the statute is therefore denied.

This then requires a resolution of the merits of the plaintiffs' request for

declaratory relief, to which we now address ourselves.

The plaintiffs' first contention is that Section 2901.16 Ohio Rev.Code is unconstitutionally vague and indefinite. This same contention has been raised in a number of cases, involving statutes of different states. There are differences in language among all of the various statutes that have been brought before the courts, and by using the same sort of hair-splitting semanticism that the plaintiffs have employed in argument, it would be possible to distinguish the Ohio statute from the others. It does not appear to us, however, that there is sufficient difference in substance among the various statutes involved in other cases to make it desirable to use so narrow and limited an approach to the problem. It seems preferable to take a stand with one group or the other of the divided authorities.

Abortion statutes have been held unconstitutionally vague in the cases of California v. Belous, (1969) 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194, cert. denied, 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970); United States v. Vuitch, 305 F.Supp. 1032 (D.D.C.1969), prob. juris. noted, 397 U.S. 1061, 90 S.Ct. 1497, 25 L.Ed.2d 683 (1970); and Roe v. Wade, 314 F.Supp. 1217 (N.D. Texas 1970). Contrary holdings are found in Babbitz v. McCann, *supra* and Rosen v. Louisiana State Board of Medical Examiners, 318 F.Supp. 1217 (E.D. La. New Orleans Div. 1970). The question was raised, but not decided, in Doe v. Bolton, *supra*.

[3] We believe that the better reasoning is found in those cases which hold that there is no unconstitutional vagueness in the abortion statutes which they consider. It appears to us that the vagueness which disturbs the plaintiffs herein results from their own strained construction of the language used, coupled with the modern notion among law review writers that anything that is not couched in numerous paragraphs of fine-spun legal terminology is too imprecise to support a criminal conviction. See Davis v. Toledo Metropolitan Housing Authority, 311 F.Supp. 795, 797 (N.D.Ohio W.D.1970). The words of the Ohio statute, taken in their ordinary meaning, have over a long period of years proved entirely adequate to inform the public, including both lay and professional people, of what is forbidden. The problem of the plaintiffs is not that they do not understand, but that basically they do not accept, its proscription.

The second contention of the plaintiffs and those *amicus curiae* who support their position is that the Ohio abortion statute deprives them of the right of privacy which is supposedly protected by several amendments to the Constitution of the United States. The arguments and authorities cited go on at inordinate length, but when the meringue is sluiced away, they come down to the contention that the decision of the Supreme Court in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), which recognized the right of marital privacy by voiding a statute preventing dissemination of contraceptive information and devices, must by extension protect the right to destroy the product of conception after it has taken place.

[4] Again the authorities are divided, some courts accepting the plaintiffs' view, and others refusing to do so. The majority of this Court do not accept the plaintiffs' contentions as constitutionally valid, but believes that the cases which do accept them have not been based on a proper legal or factual understanding. The plaintiffs' contentions seek to extend far beyond the holding in the *Griswold* case this "right of privacy", which is nowhere expressly mentioned in the Constitution or its amendments, but is only found in the "penumbra" of those articles. Rights, the provision of which is only implied or deduced, must inevitably fall in conflict with the express provisions of the Fifth and Fourteenth Amend-

ments that no person shall be deprived of life without due process of law. The difference between this case and *Griswold* is clearly apparent, for here there is an embryo or fetus incapable of protecting itself. There, the only lives were those of two competent adults.

[5] Without going into all of the myriad of cases and texts that deal with various aspects of this problem, the question resolves itself into whether or not the state has a legitimate interest to legislate for the purpose of affording an embryonic or fetal organism an opportunity to survive. We think it has and on balance it is superior to the claimed right of a pregnant woman or anyone else to destroy the fetus except when necessary to preserve her own life.

One of the great puzzles of the law is why its practitioners blithely argue their cases and make their decision in total disregard, if not ignorance, of the laws of nature. Automobile collision cases, for example, are often decided on the basis of facts which are completely impossible under the physical laws of motion and mechanics. So in this area, those decisions which strike down state abortion statutes by equating contraception and abortion pay no attention to the facts of biology.

The evidence offered by the defendants in this case shows clearly, conclusively, and in detail that neither the human ovum or spermatozoon are alive, or capable of independent life, in the accepted meaning of that word. One dictionary definition of the word "life" is

> that quality or character [that] distinguishes an animal or a plant from inorganic or dead organic bodies and which is especially manifested by metabolism, growth, reproduction and internal powers of adaptation to the environment. Webster's New International Dictionary of the English Language (2nd ed. 1934).

Biologically, when the spermatozoon penetrates and fertilizes the ovum, the result is the creation of a new organism which conforms to the definition of life just given. Although this is a definite beginning, there is no assurance in any particular case as to how long the life thus begun will continue. It may endure only a few hours or days, or it may continue in excess of a century, so far as human life is concerned. In other life forms it may continue for many measurable centuries, or even for an immeasurable and endless period. Thus when a new life comes into being with the union of human egg and sperm cells, it may terminate, or be terminated, at any moment after it commences, and before, at, or after the particular developmental process called "birth" takes place. Such terms as "quick" or "viable", which are frequently encountered in legal discussion, are scientifically imprecise and without recognized medical meaning, and hence irrelevant to the problem here presented. As scientific knowledge of prenatal physiological processes increases, medical intervention will have a greater chance of avoiding premature termination of lives of children, both before and after birth.

[6] Thus contraception, which is dealt with in *Griswold*, is concerned with preventing the creation of a new and independent life. The right and power of a man or a woman to determine whether or not to participate in this process of creation is clearly a private and personal one with which the law cannot and should not interfere.

It seems clear, however, that the legal conclusions in *Griswold* as to the rights of individuals to determine without governmental interference whether or not to enter into the processes of procreation cannot be extended to cover those situations wherein, voluntarily or involuntarily, the preliminaries have ended, and a new life has begun. Once human life has commenced, the consti-

tutional protections found in the Fifth and Fourteenth Amendments impose upon the state the duty of safeguarding it.

Obviously, of course, there are limits to the protection which the state can and must extend to human life, but these are clear and well-marked in the law, and have been for centuries, essentially on the basis that "self-preservation is the first law of nature". Thus throughout the development of our law, self-defense has always been recognized as a justification for homicide. Hence the provision in the statute here in question that abortion is noncriminal when it is necessary, or declared by two physicians to be necessary, to preserve the life of the mother. One human life may legally be terminated when doing so is necessary to preserve or protect another or others.

There is authority for the proposition that human life commences at the moment of conception.

> Biologically speaking, the life of a human being begins at the moment of conception in the mother's womb. 42 Am.Jur.2d, Infants § 2 at p. 9 (1968).
>
> From the viewpoint of the civil law and the law of property, a child *en ventre sa mere* is not only regarded as human being, but as such from the moment of conception * * * which it is in fact. Bonbrest v. Kotz, 65 F.Supp. 138, 140 (D.D.C.1946).
>
> medical authority has recognized long since that the child is in existence from the moment of conception * * W. Prosser, The Law of Torts, § 56 at 355 (3rd ed. 1964).

In this connection it should be noted that Ohio never did follow Mr. Justice Holmes's opinion in Dietrich v. Inhabitants Northampton, 138 Mass. 14, 52 Am.Rep. 242 (1884), which for more than half a century fouled up the tort law with respect to pre-natal injuries, but is now pretty well abandoned by all courts except those which, once having made a mistake, cannot admit it, but expect the legislature to rescue the public from the consequences of their error. The courts of Ohio have never hesitated to protect a child merely because it was unborn at the time of injury.

If the law is in accord with science for the purpose of protecting property rights, how can it possibly not be in accord with science for the purpose of protecting life itself, without which no property right has any worth or value whatsoever?

It should perhaps be mentioned that the implication, or sometimes the express statement, found in arguments of persons in the position of the plaintiffs in this case, which equates the necessity of giving birth to a child with the necessity of rearing the child, has no foundation in law or fact. The law may take permanently from its natural parents a child who is neglected by them, and the frequent pusillanimity of courts and social agencies in this regard does not change the legal situation. The statutes of practically all states provide for the voluntary surrender of children. When the statutes are complied with, the child is legally and practically as dead to its natural parents as if it had been aborted, stillborn, or had died in infancy. The validity and effectiveness of surrender statutes have been upheld in every case in which they have been questioned. There is no need for parents to terminate an undesired pregnancy by killing the unborn child physically, when with less risk to themselves its legal death can so easily be procured.

It is our conclusion that Section 2901.16 Ohio Rev.Code is a valid and proper exercise of the power of the state.

[7] The plaintiffs' contention that the abortion statute is in violation of the equal protection clause of the Fourteenth Amendment requires little consideration. This statute, § 2901.16 Ohio Rev.Code is clearly non-discriminatory upon its face. There is nothing in the evidence before the Court to

show any official discrimination in the application of the statute, or in commencing prosecutions under it.

[8] Assuming, *arguendo*, that the contentions of the plaintiffs that wealthy persons can shop for more complaisant physicians, or can travel to remote places where abortion is legal, while poor people cannot, have a sound basis in fact, the situation is not inherent in the language of the statute. Neither is it caused, nor could it be cured, by either action or inaction on the part of the government, either state or national. The equal protection clause is not designed to prevent that inequality which is often found in life and in nature, nor could any law be framed to do so. So far as this case is concerned, on the evidence adduced, the social and economic conditions alleged by plaintiffs as a basis for their equal protection argument, do not affect any of the actual parties, and hence the classes they represent. In seeking a temporary restraining order the plaintiffs appeared to contend that only the force of the law stood in the way of plaintiff Mary Doe undergoing the abortion she desired, and the other plaintiffs desired her, to have. It was not claimed that her economic or social situation would prevent her from getting an abortion.

We do not find that § 2901.16 Ohio Rev.Code is in any way violative of the equal protection clause of the Fourteenth Amendment.

[9] The contention that the Ohio abortion statute contravenes the Eighth Amendment proscription of cruel and unusual punishment is unworthy of serious consideration. It may seem cruel to a hedonist society that "those who dance must pay the piper", but it is hardly unusual, and the language of the amendment is in the conjunctive, not the disjunctive. In the complexities of human life it is not always possible to foretell with exactitude the entire consequences of even the simplest or most innocent action. But if it is known generally that an act has possible consequences that the actor does not desire to incur, he has always the choice between refraining from the act, or taking his chance of incurring the undesirable consequences. There are no other alternatives. This is peculiarly true with respect to the bearing of children. If one gambles and loses, it is neither statute nor constitution that determines the price, or how it shall be paid. The result is not punishment, but merely the *quid pro quo*.

The controversial problems of the plaintiffs should be addressed to the state's legislature and not the courts for solution. The courts ought not to be expected to provide a remedy for all of the ailments afflicting society.

For the foregoing reasons, the plaintiffs are not entitled to a declaratory judgment invalidating Ohio's abortion statute, Section 2901.16 Ohio Rev.Code.

This opinion is adopted as findings of fact and conclusions of law. Judgment will be entered in favor of the defendants dismissing the amended complaint.

BEN C. GREEN, District Judge (dissenting):

I concur in the determination of the majority that plaintiffs herein have proper standing to maintain this action and that this Court should not abstain from the exercise of jurisdiction. However, I cannot agree with the decision on the merits of the declaratory judgment proceeding.

In its present form, the Ohio statute on abortion which emanates from legislation first enacted 136 years ago, provides as follows:

> *Ohio Revised Code* § 2901.16 *Attempt to procure abortion*
>
> No person shall prescribe or administer a medicine, drug, or substance, or use an instrument or other means with intent to procure the miscarriage of a woman, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose.

> Whoever violates this section, if the woman either miscarries or dies in consequence thereof, shall be imprisoned not less than one nor more than seven years.

Plaintiffs contend that this statute is unconstitutionally vague and indefinite. One of the criteria against which the validity of a criminal statute, such as O.R.C. § 2901.16, must be measured is reflected in the holding of the Supreme Court in Connally v. General Construction Co., 269 U.S. 385, 46 S.Ct. 126, 70 L.Ed. 322 (1926), that:

> * * * a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process of law. *Id.*, p. 391, 46 S.Ct. p. 127.

The majority opinion passes off the question of vagueness of this statute with the statement that:

> It appears to us that the vagueness which disturbs the plaintiffs herein results from their own strained construction of the language used, coupled with the modern notion among law review writers that anything that is not couched in numerous paragraphs of fine-spun legal terminology is too imprecise to support a criminal conviction.
>
> * * * The words of the Ohio statute, taken in their ordinary meaning, have over a long period of years proved entirely adequate to inform the public, including both lay and professional people, of what is forbidden. The problem of the plaintiffs is not that they do not understand, but that basically they do not accept, its proscription.

It is my opinion that the difficulty with the statute in question is not its failure to be phrased in "numerous paragraphs of fine-spun legal terminology", but rather its attempt to define a medical problem in terms that are not understandable by the medical profession. A continuing complaint of the medical profession is that the laws in general, and judicial decisions, are not responsive to the realities of medical science. It is interesting to note that while the body of the statute condemns the attempt to procure a "miscarriage", the statute is captioned "Attempt to procure abortion." This failure of this statute, and others like it, to observe the medical distinction between abortion and miscarriage has been noted (1 O.Jur.2d, Abortion, § 2; 1 Am.Jur.2d, Abortion, § 1), and it is said that the two terms are used indiscriminately by the courts. 1 O.Jur.2d, Abortion, § 2.

An excellent discussion of the vagueness of the phrase "necessary to preserve" is found in People v. Belous, 71 Cal.2d 954, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), cert. den. 397 U.S. 915, 90 S.Ct. 920, 25 L.Ed.2d 96 (1970), wherein an abortion statute similar to that of Ohio was held unconstitutional. Reiteration of all the considerations reviewed therein which led the court to find the statute unconstitutionally vague is not necessary. However, I should like to set forth what I believe to be a primary example of the vagueness of the Ohio statute: the suicidal patient.

A pregnant woman informs her physician that if her pregnancy goes to term she will take her own life. Is an abortion *necessary to preserve* the life of that patient? The patient will not die from any physiological condition related to her pregnancy. Suicide is an intentional act (although, perhaps, not truly a volitional one), and the patient may not, in fact, carry out her threat. Assuming that the physician has strong and valid reasons to believe that his patient will take her own life, does this statute tell him whether he may legally terminate the pregnancy?

There are other questions created by this statute. How imminent must the threat of death be to warrant an abortion "to preserve life?" If permitting a pregnancy to go to term would clearly shorten the mother's life by a substantial number of years, would a physician be justified in performing an abortion in

accordance with the term "necessary to preserve her life?"

An Ohio court has recently defined a "necessary thing" as follows:

> A necessary thing may supply a wide range of wants, from mere convenience to logical completeness. City of Dayton v. Borchers, 13 Ohio Misc. 273, 232 N.E.2d 437, 441, 42 O.O.2d 193, 197 (Ohio Com.Pl.1967)

Such a definition certainly does not advise what is permitted and what is forbidden.

With regard to the assertion that the lessons of time have compensated for the deficiencies of the statute, I do not find that to be the case. I have endeavored to examine all recorded Ohio decisions construing O.R.C. § 2901.16 and the predecessor thereto, and find that not one of the cases I have reviewed construes the statutory phrase "necessary to preserve her life", or the language of similar import in the earlier statutes. (A listing of the said decisions in appended hereto). A study of the Ohio case histories offers little guidance to the physician searching for the meaning of the language "necessary to preserve her life."

No person may be required at peril of life, liberty, or property to speculate as to the meaning of penal statutes. All are entitled to be informed as to what the state commands or forbids. Lanzetta v. New Jersey, 306 U.S. 451, 453, 59 S.Ct. 618, 83 L.Ed. 888 (1939). It is my opinion that O.R.C. § 2901.16 is unconstitutionally vague. Cf. Roe v. Wade, 314 F. Supp. 1217 (D.C.N.D.Tex., 1970); United States v. Vuitch, 305 F.Supp. 1032 (D.C.D.C.1969); People v. Belous, supra.

I am also of the opinion that the statute suffers from the constitutional vices of over-breadth and violation of equal protection of the law. Roe v. Wade, supra; People v. Belous, supra. In reaching this conclusion, I find the applicable law to be well stated in People v. Belous, supra, 80 Cal.Rptr. 354, 362, 458 P.2d 194, 202:

> Although we may assume that the law was valid when first enacted, the validity of a law in 1850 does not resolve the issue of whether the law is constitutionally valid today. [Citations omitted]
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> Constitutional concepts are not static. Our United States Supreme Court said, regarding the equal protection clause of the Fourteenth Amendment: "We agree, of course, with Mr. Justice Holmes that the Due Process Clause of the Fourteenth Amendment 'does not enact Mr. Herbert Spencer's Social Statics.' [Citation] Likewise, the Equal Protection Clause is not shackled to the political theory of a particular era. In determining what lines are unconstitutionally discriminatory, we have never been confined to historic notions of equality, any more than we have restricted due process to a fixed catalogue of what was at a given time deemed to be authorized to practice surgery, carried out the limits of fundamental rights. * * *" (Harper v. Virginia State Bd. of Elections (1966) 383 U.S. 663, 669, 86 S. Ct. 1079, 1082, 16 L.Ed.2d 169; see also, Perez v. Sharp, *supra*, 32 Cal.2d 711, 727, 198 P.2d 17; Galyon v. Municipal Court, 229 Cal.App.2d 667, 671–672, 40 Cal.Rptr. 446, and cases cited therein ["[A] statute valid when enacted may become invalid by change in the conditions to which it is applied:"]. See also, Means, *supra*, 14 N.Y.L.F. 411, 514–515.)

Virtually all the cases which have considered this question recognize that when the abortion statutes were enacted the surgical procedure required in an abortion presented a substantial risk of death to the woman involved. It is also recognized that this situation no longer exists with today's medical advances. Protection of the mother from unsafe surgical procedures may well have been in the legislators' minds when they enacted the Ohio statute in 1834. Modern day medicine, however, makes induced miscar-

riage in the first trimester of pregnancy a safer procedure than delivery at full term. See, People v. Belous, supra, 80 Cal.Rptr. 360–361, 458 P.2d 200–201. In many areas the mortality rate from therapeutic abortion is less than that occasioned by childbirth. Note, Abortion Reform: History, Status and Prognosis, 21 Case W.Res.L.Rev. 521, 522–523 (1970).

Under each of the statutes enacted by the Ohio Legislature regulating the right to abortion there was exempted therefrom a classification of pregnant women whose interests were deemed superior to those of the child she was carrying. Having thus recognized that there are pregnant women whose interests rise above all others, the state may not unreasonably restrict the right of pregnant women to be included in such classification.

Viewed in its historical perspective, the Ohio statute could well have been considered as a reasonable measure when it was adopted 136 years ago. At that time the risk of death on the operating table for any surgical procedure was extremely serious, and the state, to protect the interests of its citizens, could reasonably restrict the availability of abortion to those women who faced an equally serious risk of death if the operation was not performed.

When this statute was first enacted, the discipline of psychiatry was unknown in the medical profession. Today, it is recognized that mental illness is, at least, as great a threat to human well-being as is physical illness. We also know that many factors can precipitate a permanent and incurable mental disorder, among them the strain of childbirth or the inability of the mother to cope with the responsibilities of caring for an infant.

In my opinion, the continuance of the sole exception to the abortion statute of the necessity to save life is a refusal to recognize the advance of medical science in its understanding of the mind, and can no longer be considered as representing a reasonable classification. In effect, this statute says that a woman whose continued physical life is threatened by pregnancy may secure appropriate medical help, but that a woman whose sanity is equally threatened must be condemned to a continuing existence without the human attributes of intellect and reason. I do not believe that our society can condone such a classification as reasonable when, with minimal risk to the physical well-being of the woman, the dire potential psychiatric consequences can be avoided.

Similarly, I have serious reservations regarding the exclusion from the right to abortion of the victims of forcible rape or the minor who is pregnant as the result of an uninvited incestuous relationship. The innocent victim of such a crime did not have the opportunity to refrain from the act which resulted in pregnancy. To suggest that, in the case of such an unfortunate circumstance, pregnancy is a *quid pro quo* or that "those who dance must pay the piper" strikes me an inhumane. I believe that the interests of such women in being relieved from the consequences of the violations of their body should, in a civilized society, be deemed superior to the interests of the unborn child conceived in violence or lust.

I now turn to the contention of plaintiffs' covering the question of the invasion of the right of privacy, and the relationship of the decision of the United States Supreme Court in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), to the validity of the Ohio abortion statute, O.R.C. § 2901.16.

Regarding the application of *Griswold* to the instant case, the majority distinguishes *Griswold* on the basis that the decision, which struck down a state ban on the dissemination of contraceptive information and devices, involved only the interests of two competent adults, whereas in this case "there is an embryo or fetus incapable of protecting itself." In my opinion, such an approach to *Griswold* totally disregards the constitutional doctrine enunciated therein, and looks

merely to the narrow fact issue before the Supreme Court.

The majority opinion states:

> Without going into all of the myriad of cases and texts that deal with various aspects of this problem, the question resolves itself into whether or not the state has a legitimate interest to legislate for the purpose of affording an embryonic or fetal organism an opportunity to survive. We think it has and on balance it is superior to the claimed right of a pregnant woman or anyone else to destroy the fetus except when necessary to preserve her own life.

It appears from a further reading of the majority opinion that the basis for their conclusion is a finding that human life exists from the time of conception.

I will not debate the biological or philosophical conclusion of the majority that, from the moment of conception a human life has commenced, although retired United States Supreme Court Justice Tom C. Clark does appear to take issue therewith, Clark, Religion, Morality and Abortion: A Constitutional Appraisal, 2 Loyola Univ. (L.A.) L.Rev. 1, 9–10 (1969). I am, however, more inclined to the view expressed in Doe v. Bolton, 319 F.Supp. 1048, 1055 (D.C.N.D.Ga., filed July 31, 1970) that "once conception takes place and an embryo forms, for better or for worse the woman carries a life form with the potential of independent human existence."

In my opinion, the question of whether once conception occurs life is present is not controlling on the right to abort such existence. I believe that the *Griswold* decision stands for the proposition that the interests of the embryo or foetus must be balanced against the interests of the pregnant woman, and the resolution of the ultimate question of the right to abortion hinges on the balancing of such interests. Under the principles of constitutional law enunciated in *Griswold*, the state bears the burden of demonstrating a compelling interest in restricting the rights of the pregnant woman by the enforcement of statutes limiting the availability of abortion. Accord, Doe v. Bolton, supra; Roe v. Wade, 314 F.Supp. 1217, 1222 (D.C.N.D.Tex., 1970); Babbitz v. McCann, 310 F.Supp. 293, 301 (D.C.E.D.Wis., 1970); United States v. Vuitch, 305 F.Supp. 1032, 1035 (D.C.D.C.1969). Justice Clark, in his analysis of the *Griswold* doctrine, states:

> The result of these decisions is the evolution of the concept that there is a zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children, and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution. No one will deny that a State has a valid interest in regulating the well-being of its inhabitants, especially when it is dealing with children, who are more susceptible to undesirable influences. We have also seen that a State may not unreasonably interfere with the intimate relations of its inhabitants. When deciding on the constitutional restraints imposed on a State's interference with individual rights, the vital question becomes one of balancing. It must be determined at what point the State is interfering with individuals and at what point it is exercising valid authority by regulating the well-being of children. 2 Loyola Univ. (L.A.) L. Rev. 1, 8.

As previously indicated herein, I do not consider the protection of an embryo in its early stages of existence as a compelling state interest sufficient to justify the sweeping scope of the statute in this modern era. In reaching the conclusion that "once human life has commenced, the constitutional protections found in the Fifth and Fourteenth Amendments impose upon the state the duty of safeguarding it", the majority opinion does not consider the countervailing consideration of the rights of the pregnant wom-

an which are impinged upon by such legislation.

Further, I do not find that the history of this statute, its interpretation by the Ohio courts, and the recognition of rights of unborn children by the Ohio courts, supports the argument that the state has evidenced a compelling interest in the *total* protection of fetal life.

When the Ohio abortion legislation was first enacted, it was part of a six-section statute, 32 v Stat. 20. The first section declared it to be a misdemeanor to administer drugs or use an instrument with the intent to procure the miscarriage of any pregnant woman. The second part of the statute declared it to be a high misdemeanor, subject to imprisonment for seven years, to do the same acts with regard "to any woman, pregnant with *a quick child*", in the case of the death of such child or mother. The third section made it an offense for a physician, or other person, while in a state of intoxication to prescribe any poison, drug or medicine to another person, so as to endanger such latter person's life. The fourth section made it an offense for any physician, or person, to prescribe a drug or composition, the true nature and composition of which was unknown, on the representation that the same was a secret medicine. The fifth and sixth sections were venue and the effective date of the legislation.

It thus seems that the first Ohio abortion law was part of a package intended to regulate the proper practice of the medical profession. It is plain that the more serious offense thereunder was restricted to those instances where the condemned practices were practiced upon a woman pregnant with a *quick child*, that is, a child whose uterine movements could be felt by the mother, and did not apply prior thereto. Wilson v. State, 2 Ohio St. 319 (1853).

The 1834 statute was amended effective April 13, 1867, by the repeal of section two of the original Act and enactment of a substitute therefor, 64 v Stat. 135. That amended statute, in pertinent part, provided:

> * * * that any physican or other person who shall administer, or advise to be administered, to any woman *pregnant with a vitalized embryo, or foetus, at any stage of utero-gestation*, any medicine, drug, or substance whatever, or who shall use or employ * * any instrument or other means with intent thereby to destroy such *vitalized embryo, or foetus*, unless the same shall have been necessary to preserve the life of the mother, or shall have been advised by two physicians to be necessary for such purpose, shall, in case of the death of such *vitalized embryo, or foetus*, or mother in consequence thereof, be deemed guilty of a high misdemeanor * * * (emphasis added)

It is argued that this change from the phrase "any woman, pregnant with a quick child" to the phrase "any woman pregnant with a vitalized embryo, or foetus, at any stage of utero-gestation" was:

> * * * in recognition of medical science findings that there was a live developing organism even before the mother was able to feel movement of the child [and that] the Ohio General Assembly [thereby] recognized that the child was alive prior to quickening and that an embryo became "vitalized" at the earliest stage of utero-gestation. Intervenor's brief, pp. 32–33.

In my opinion, the above argument is only partially correct.

The statute of 1867 speaks of a "vitalized embryo or foetus at any stage of utero-gestation." To accept the argument that this language applies to an embryo or foetus from the time of conception would render the word "vitalized" as used in the statute, surplusage. There is an embryo or foetus present from the earliest stage of utero-gestation, and, therefore, there would be no need to add the modifier of "vitalized" if the intent of the statute was to signify

fetal existence from the time of conception.

Webster's Third New International Dictionary (unabridged) sets forth the following definition of the word "vitalized":

> VITALIZE 1: to endow with vitality: give life or animation to: make vigorous or active * * *
>
> VITALIZE signifies to arouse, usually something more or less inert or lifeless, to vital activity * * *

The word "vital" is stated by Webster's to be "akin to Latin vivere to live—more at QUICK", and, in part, is defined as:

> * * * existing as a manifestation of life * * * having or characterized by life * * * full of life and vigor * * * characteristic of life or living beings: inhering in the living or organic.

Taking the usual meanings of the foregoing words into account, I would consider a "vitalized embryo or foetus" as one that, in the course of prenatal development, had reached the point of being capable of sustaining its own life form. The use of the term "vitalized" in the statute would then have some rational meaning, signifying the distinction between the embryo or foetus totally dependent on the mother for life support and that which had developed to the stage of capability of independent life. That state of existence is commonly referred to as viability, a viable unborn child being one that would be capable of sustaining life if removed from the womb. Such a construction fully comports with the contention that the statute was amended in light of advances of medical knowledge, for the old standard of quickening was based on the mother's totally subjective ability to feel life, whereas the new standard, so interpreted, would represent a more objective approach to the question of fetal development.

A further indication that the amendment of 1867 was not meant to cover all stages of pregnancy is the fact that only section two of the Act of 1834 was repealed. Section one, which had been construed as making it an offense to do like acts with regard to a pregnant woman at any stage of pregnancy, remained. The operative terms of the two statutes, however, were not the same. To assume that the legislature intended them to have the same reach would require one to ignore the plain differences in their language.

The abortion statute was again amended at the time of its incorporation into the Revised Statutes of Ohio, R.S. § 6815. In that enactment the reference to "vitalized embryo or foetus at any stage of utero-gestation" was dropped, and the statute read:

> Whoever, with intent to procure the miscarriage of any woman prescribes or administers to her any medicine, drug, or substance whatever, or, with like intent, uses any instrument or means whatever, unless such miscarriage is necessary to preserve her life, or is advised by two physicians to be necessary for that purpose shall, if the woman miscarries or dies in consequence thereof, be imprisoned in the penitentiary not more than seven years nor less than one year.

It is interesting to note that this statute, substantially the same as O.R.C. § 2901.16, was preceded in the Revised Statutes, Sections 6813 and 6814, by those portions of the original Act of 1834 concerning intoxicated physicians and the use of secret drugs, and was followed by the statute defining the offense of rape, R.S. § 6816.

There is no legislative history available which can enlighten us as to the intent of the Ohio Legislature in the adoption of the various versions of the abortion law. I find it difficult to accept the argument that such law historically represents the interest of the state in protecting fetal life from the time of conception when, as I believe to be true, the law originated as part of regulatory measures governing the practice of medicine and as a high misdemeanor was applicable only to the case of a woman pregnant with a quick child, and in its

first reenactment did not proscribe an offense prior to the time the embryo or foetus was "vitalized."

An indication that the State of Ohio's interest in the subject of abortion is as a matter of protection of public morality, rather than for protection of fetal life, is found in another section of the Ohio statutes. Chapter 2905 of the Ohio Revised Code is entitled "Offenses Against Chastity." Therein, matters relating to the subject of abortion are made the subject of three additional criminal offenses. It is a crime to sell or give away drugs for procuring abortion or miscarriage, O.R.C. § 2905.32, or to advertise the same, O.R.C. § 2905.33. Under O.R.C. § 2905.34, which is entitled "Selling, exhibiting, and possessing obscene literature or drugs for criminal purposes", included among the several offenses defined therein it is made a felony to:

> * * * knowingly sell, lend, give away, exhibit, or offer to sell, lend, give away, * * * or have in his possession or under his control * * * *a drug, medicine, article or thing intended for causing an abortion*, or write, print, or cause to be written or printed a * * * notice giving information when, where, how, of whom, or by what means any of such articles or things can be purchased or obtained * * *. (emphasis added)

Prior to the 1965 decision of the United States Supreme Court in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), declaring unconstitutional a state ban on the dissemination of information on contraception, the specific references in Sections 2905.32, 2905.33 and 2905.34 of the Ohio Revised Code to the subject of abortion were each coupled with a similar proscription with regard to the prevention of conception. Thus, prior to *Griswold*, the language of O.R.C. § 2905.34 emphasized in the preceding paragraph read:

> * * * a drug, medicine, article, or thing intended for the prevention of conception or for causing an abortion.

Subsequent to the *Griswold* ruling each of the statutes was amended to delete the reference to contraceptive practices. The concomitant ban on abortion remains.

The most compelling evidence that the present Ohio statute is not aimed primarily at the protection of fetal life comes from the Ohio Supreme Court itself, State v. Tippie, 89 Ohio St. 35, 105 N.E. 75 (1913). The *Tippie* case involved the conviction of a physician under Section 12412 of the General Code, which was a recodification of Section 6815 of the Revised Statutes and the predecessor of O.R.C. § 2901.16.

In *Tippie*, the facts were that the woman had attempted to abort herself by the most primitive of methods, and when the resultant infection occurred, she sought medical assistance. Following three external examinations, Dr. Tippie had reason to believe that the foetus was dead. He then determined to make an internal examination and contemplated the possibility of performing an abortion. Chloroform was administered as an anesthetic, and the examination proceeded. Dr. Tippie then discovered that the foetus was not dead, and decided "to let the woman alone and give her the benefit of the doubt." As he was completing his procedures the patient died from the effects of the chloroform.

In the Court of Appeals it was urged that error had been committed by the trial court's refusal to instruct the jury that the doctor was entitled to an acquittal if he had undertaken the fatal procedure with an honest belief, based on his prior examinations, that the foetus was dead. The court agreed with that contention, Tippie v. State, 1 Ohio App. 13 (1913), stating:

> We think, therefore, that the removal of a dead foetus was not, in contemplation of the statute, producing a miscarriage.
>
> If done unlawfully, by unprofessional hands, or without reasonable grounds to believe the foetus to be dead, and death to the patient results, the opera-

> tor would be guilty of manslaughter, but not of the crime charged.
>
> * * * * * *
>
> Intent is of the essence of the crime, and defendant should be allowed to show an innocent intent and have the jury instructed that the evidence with reference thereto may be considered. *Id.* p. 19

However, in the Ohio Supreme Court that holding was reversed. The Supreme Court postulated the question as:

> Is the administering of chloroform (which is not an abortive drug) with the intent to produce anesthesia, as a preliminary step to carrying out the intent of removing the fetus, if it be found to be dead, administering a drug with intent to procure miscarriage? 89 Ohio St. 35, 39–40, 105 N.E. 75, 77.

The answer was in the affirmative. Without specifically considering the history of the statute, as had been done by the Court of Appeals, the Supreme Court held:

> We remark, first, that the evolution of this statute of Ohio seems to show that it was enacted in its present form to cover any case of procuring the premature removal or expulsion of the fetus, *living or dead*, with other intent than to preserve the mother's life.
>
> Second, the object of the statute is to prevent any operation, or use of drugs, for the purpose of producing an abortion upon a woman deemed to be pregnant, except to save her life. ***The reason and policy of the statute is to protect women and unborn babes from dangerous criminal practice, and to discourage secret immorality between the sexes, and a vicious and craven custom amongst married pairs who wish to evade the responsibilities and burdens of rearing offspring.*** *Id.* p. 40, 105 N.E. p. 77. (emphasis added)

It is inconceivable to me to accept the premise that the Ohio statute is primarily for the protection of *all* fetal life when the Ohio Supreme Court has declared that the existence of a live foetus is immaterial to a conviction under such statute. In my opinion, from the overall tenor of the Ohio Supreme Court's opinion, the protection of "unborn babes", enumerated as but one of the underlying objects of the statute, was secondary to the morality considerations inherent in the statute which were enunciated by that court.

It is also said that under the Ohio statute it is apparent that the offense defined by O.R.C. § 2901.16 may be committed although the woman was not actually pregnant, if the parties acted under a mistaken opinion to the contrary, and death resulted. 1 O.Jur.2d, Abortion, § 8. Such a view would indicate that the statute was intended to protect the woman involved, and certainly militates against the contention that the intent of the statute is to protect fetal life.

In the majority opinion certain rights accorded unborn children are reviewed, and it is then asserted that:

> If the law is in accord with science for the purpose of protecting property rights, how can it possibly not be in accord with science for the purpose of protecting life itself, without which no property right has any worth or value whatsoever?

I do not find that the law of Ohio recognizes property rights of unborn children to such an extent that the reasonable corollary would be to recognize superior rights of such child, at all times subsequent to conception, to those of the mother.

While it is correct that Ohio law recognizes an unborn child as having a right of inheritance, and thus such child is, in law, considered in esse from the date of its conception, ***the unborn child must be born alive*** in order for the expectancy to fully vest. 56 O.Jur.2d, Wills, § 615.

The Ohio courts do not appear to have yet passed upon the question of the right of a child who sustained a prenatal injury to recover for such injury follow-

ing a live birth. There appears to be a split of authority on this question, some jurisdictions denying any recovery for injuries arising from prenatal negligence, others granting an unqualified right of action, while still others condition the right to recovery upon a showing that the injury was inflicted at a time when the unborn child was viable. Annot. 27 A.L.R.2d 1256.

The Ohio courts have, on the other hand, considered the civil responsibility of a person negligently causing the death of an unborn child. While recognizing a right of action under the Ohio wrongful death statute, O.R.C. § 2125.01, the Supreme Court expressly conditioned such right to the instance of a *viable* child. Peterson v. Nationwide Mutual Ins. Co., 175 Ohio St. 551, 197 N.E.2d 194 (1964); Jasinsky v. Potts, 153 Ohio St. 529, 92 N.E.2d 809 (1950); Williams, an Infant v. Marion Rapid Transit, Inc., 152 Ohio St. 114, 87 N.E.2d 334 (1949). Such a limitation is in accord with the overwhelming weight of authority. Mace v. Jung, 210 F.Supp. 706 (D.C.Ala., 1962); Annot. 15 A.L.R.3d 992.

At common law it was held that no crime was committed by the causing of the death of a stillborn child, and that rule appears to prevail in the majority of jurisdictions in the United States, 40 Am.Jur.2d, Homicide, § 9. There is one Ohio Common Pleas decision to the contrary, State v. Dickinson, 18 Ohio Misc. 151, 248 N.E.2d 458 (1969). Therein, the court held, on the authority of the Ohio Supreme Court rulings on the civil question of wrongful death, that a *viable* unborn child was a "person" within the contemplation of the vehicular homicide statute, O.R.C. § 4511.18.1. It is clear from the court's opinion that such decision was controlled by the question of viability.

I therefore find that, under the law of Ohio, the property rights of unborn children, which the majority consider to be of great importance, either do not vest until viability occurs, or, if vested prior thereto, fail if the unborn child does not survive childbirth. Such a state of the law, in my opinion, affords little support for the Ohio abortion statute on the basis that, from the moment of conception, an unborn child is a person entitled to assert constitutional rights paramount to those of the mother. I cannot believe that under our system of constitutional law, a person who, in Ohio, maliciously or negligently terminates the existence of a non-viable foetus can do so without fear of criminal or civil sanctions, but that a physician who, exercising his best medical judgment, performs an abortion when the foetus has not yet reached viability can only do so facing the real possibility of criminal conviction if a lay jury disagrees with his opinion.

It has been suggested that the Ohio statute affords a safeguard to the individual doctor from being "second-guessed" by a jury, in that it provides that an abortion may be performed if such action "is advised by two physicians to be necessary" to save the mother's life, O.R.C. 2901.16. It was contended at oral argument that the "two physicians" rule is a complete defense to prosecution under the statute.

Disregarding the practical considerations of the economic burden that consultation with other doctors would impose upon the patient and the possibility that, under emergency conditions, such consultation might not be medically feasible, I do not find that argument to be sound. No Ohio case has been cited or found, nor has any been cited from any other jurisdiction having a similar statutory provision, which would vindicate that contention.

The "necessity" clause of the Ohio abortion law has been considered but once by the Ohio Supreme Court, in passing upon the issue of whether the prosecution had the burden of proving that the operation was not necessary, or whether the defendant had the burden of proving necessity as a matter of defense. Moody v. State, 17 Ohio St. 110 (1866). Therein, the court stated:

* * * The statute does not declare every procurement of an abortion to

be an offense, but does so only when it is not done for the purpose of saving the life of the mother * * *

* * * * * *

It is the absence of the necessity of saving life, that is the essential part of the negative clauses, which enters into the statutory description of the offense; and in the contemplation of the statute, the advice of two physicians is *sufficient evidence* of the existence of such necessity.

Since, then, such advice is *only evidence* of the necessity that forms the essential negative description of the crime in both negative clauses, and as it may usually be readily shown by the accused, and must ordinarily be so difficult, if not impossible, to be shown on the part of the prosecution, it might well be held, upon reason as well as authority, that it is unnecessary for the state to prove that the producing the abortion was not advised by two physicians further than such negative fact may be implied from the proof that it was not necessary to preserve the life of the mother. *Id.* pp. 112–113 (emphasis added)

As I read the *Moody* decision, the Ohio Supreme Court, by its use of the phrases "sufficient evidence" and "only evidence", has said that the defendant in an abortion prosecution bears the burden of proving necessity to save life, and proof that such abortion was advised by two physicians would be prima facie evidence of such fact. If proof that the abortion was advised by two physicians is only prima facie evidence of the necessity to save life, it necessarily follows that such evidence would be subject to rebuttal by the prosecution. Hence, the "two physicians" rule is not a complete defense to prosecution under the statute.

There is one other aspect to this litigation, not considered in the majority opinion, to which I wish to address myself: the impact of this statute on the medical profession, and to a lesser degree the rights of those other plaintiffs herein who contend that they are hampered in their professions by its existence. Plaintiffs Steinberg, Fitzgerald, Frank and Argow contend that this statute prevents them from the proper discharge of their professional responsibilities in the respective fields of obstetrics and gynecology, psychiatry, social work, and the ministry.

Defendants and intervenor contend that as to those persons who claim that they are prevented from orally disseminating information about abortion the statute imposes no restraints, in that it only reaches the actual attempt to procure an abortion. That position is plainly incorrect.

If an attempt to procure an abortion were made pursuant to such advice, the party not actually performing the operation would, under Ohio law, be deemed culpable as an aider and abettor. 1 O.Jur.2d, Abortion, § 3. Such a conviction of a physician has, in fact, been affirmed by the Ohio courts, State v. Smith, appeal dismissed 165 Ohio St. 247, 135 N.E.2d 63 (1956), and was the factual predicate from which the landmark case of People v. Belous, supra, arose.

Assuming for the sake of argument that the contention of defendants and intervenor was correct, this would place the physician in the position of saying to his patient that, in the exercise of his best medical judgment, an abortion was advisable but that the law prevented him from performing the same. I cannot conceive of placing a professional man in a more frustrating position.

The duty and judgment of the physician, the necessity and welfare of the patient, and the rights of both, cannot be subjected to arbitrary and unreasonable legislative interference, dictation and infringement. United States v. Freund, 290 F. 411, 414 (D.C.Mont., 1923); see also 70 C.J.S. Physicians and Surgeons § 3, p. 820 et seq. It is my belief that Section 2901.16 of the Ohio Revised Code, by virtue of its vagueness and lack of responsiveness to the realities of modern medicine, can no longer be considered as a reasonable regulatory

measure as it affects the practice of medicine.

In Williams v. Marion Rapid Transit, Inc., 152 Ohio St. 114, 126, 87 N.E.2d 334, 339 (1929), the Ohio Supreme Court expressed the hope that "the law will keep pace with science." In my opinion, continued enforcement of O.R.C. § 2901.16 keeps the law many years behind the medical profession.

The "chilling" effect of legislation of this scope upon the medical profession has been recognized. In Judge Neville's concurring opinion in Doe v. Randall, 314 F.Supp. 32 (D.C.Minn., 1970), he states:

> I subscribe to the view that the entire medical profession and innumerable pregnant women live under the sword of Damocles. The exercise of their best medical judgment, the giving of advice and the pregnants' freedom of choice is "chilled" by the cloud of a statute which renders their actions illegal and puts them in jeopardy of criminal prosecution with the resultant publicity, possible public disgrace, loss of hospital privileges, threat of license revocation, etc. *Id.* p. 36

In Babbitz v. McCann, 310 F.Supp. 293 (D.C.E.D.Wis., 1970) the court entered a declaratory judgment holding the Wisconsin abortion statute unconstitutional, but declined to enter an order enjoining the operation of said statute. That decision on the injunctive side of the suit has now been withdrawn, and a permanent injunction entered restraining further prosecutions under the abortion law (order of November 18, 1970). The Wisconsin authorities had announced that they would not abide by the declaratory judgment in pursuing further criminal actions under the challenged statute. It appears that a substantial factor influencing the court's decision to reverse its prior holding was the "chilling" effect it believed the state's determination to continue to enforce the abortion law would have upon the medical profession.

My dissent herein should not be construed as indicating a belief that the state has no right to adopt legislation controlling on the subject of abortion. I wish to make it quite clear that I recognize the right of the state to adopt and enforce reasonable regulations in this area. Such legislation, however, must be couched in precise and relevant terms, and must accord proper recognition to the interests of all persons concerned therewith. A number of states have adopted therapeutic abortion laws which, in my opinion, are a step in the right direction. Note, Abortion Reform: History, Status and Prognosis, 21 Case W.Res.L.Rev. 521–522 (1970).

It is suggested in the majority opinion that this problem is one for the legislature and not for the courts. Serious efforts to achieve legislative reform have been undertaken in recent years, have been subject to intensive lobbying by those interests opposing any liberalization of the abortion laws, and have failed. While the courts are not a panacea for all of society's ills, they cannot refuse to act simply because the legislature fails to do so. It took a decision of the United States Supreme Court to motivate the Ohio Legislature to remove from the Ohio statutes the archaic ban on the dissemination of information with regard to contraception.

The fatal flaw which I find in O.R.C. § 2901.16 is that it carries forward the constitutional standards of Nineteenth Century America into the complex and advanced structure of our Twentieth Century society. Such standards cannot withstand the changes created by the transition from the primitive frontier life of 1834 to the onmoving urban existence of 1970.

I am of the opinion that a woman has the private right to control her own person, which necessarily encompasses the fundamental right to choose whether to bear children.

I am also of the opinion that a physician has the right and duty to practice his chosen profession to the best of his ability, which necessarily includes the

discretion to perform those procedures which, in his expert medical judgment, he deems to be in his patient's best interests.

The question of producing a miscarriage during the early stages of a woman's pregnancy, and certainly prior to viability, should be a private matter between the woman and her physician. A woman who seeks therapeutic abortion and a physician who concurs in such course of treatment, or who in the first instance recommends the same, should not be subject to a virtually absolute threat of criminal prosecution and punishment unless the state has a compelling interest in regulating such conduct. I do not believe that this record, or those matters of which the court could take judicial notice, establish any compelling state interest which would justify the enforcement of legislation interfering with a woman's right to secure, and a physician's right to perform, a therapeutic abortion during the early stages of pregnancy.

I must respectfully enter my dissent from the opinion of the majority herein, as I believe the Ohio abortion statute, O.R.C. § 2901.16, to be unconstitutionally vague, overly broad, violative of equal protection of the law, and in conflict with the principles set forth by the Supreme Court in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965). I would enter a declaratory judgment finding the said statute to be invalid for the reasons set forth herein.

APPENDIX

Ohio decisions under O.R.C. § 2901.16 and the predecessors thereto:

Ohio Supreme Court

Wilson v. State, 2 Ohio St. 319 (1853)

Robbins v. State, 8 Ohio St. 131 (1857)

Moody v. State, 17 Ohio St. 110 (1866)

Ohio v. Barker, 28 Ohio St. 583 (1876)

Tabler v. Ohio, 34 Ohio St. 127 (1877)

Benedict v. State, 44 Ohio St. 679, 11 N.E. 125 (1887)

State v. McCoy, 52 Ohio St. 157, 39 N.E. 316 (1894)

State v. Tippie, 89 Ohio St. 35, 105 N.E. 75 (1913)

Ohio v. Lehr, 97 Ohio St. 280, 281, 119 N.E. 730 (1918)

Ohio v. Karcher, 155 Ohio St. 253, 98 N.E.2d 308 (1951)

Ohio v. Smith, 165 Ohio St. 247, 135 N.E.2d 63 (1956)

Ohio Appellate

Florien v. Ohio, 18 Ohio Civ.Ct.R. 596 (1897)

Waite v. Ohio, 4 Ohio App. 451 (1915)

Jones v. State, 11 Ohio App. 441 (1919)

Schneider v. State, 1 Ohio Law Abst. 75 (1922)

Vargo v. State, 1 Ohio Law Abst. 830 (1923)

Schunn v. State, 2 Ohio Law Abst. 186 (1923)

Emery v. State, 3 Ohio Law Abst. 62 (1924)

Shellenberger v. Ohio, 26 Ohio Law Rep. 619 (1928)

Clyne v. Ohio, 32 Ohio Law Rep. 477 (1930)

Novaksky v. State, 18 Ohio Law Abst. 313 (1934)

State v. Hollos, 76 Ohio App. 521, 65 N.E.2d 144 (1944)

Ohio v. Jones, 80 Ohio App. 269, 70 N.E. 2d 913 (1946)

State v. Taylor, 83 Ohio App. 76, 77 N.E. 2d 279 (1947)

State v. Coran, 87 Ohio App. 238, 94 N.E.2d 562 (1948)

State v. McDaniel, 85 Ohio App. 529, 89 N.E.2d 664 (1949)

State v. Roche, Ohio App. 135 N.E.2d 789, 72 Ohio L.A. 462 (1955)

State v. Brown, Ohio App., 137 N.E.2d 609, 73 Ohio L.A. 349 (1955)

State v. Allgood, 84 Ohio L.A. 367 (1959)

Ohio v. Ball, 1 Ohio App.2d 297, 204 N.E.2d 557 (1964)

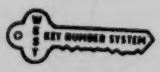
Common Pleas Court

State v. Springer, 4 Ohio Dec. 169

Geer v. Ohio, 16 Ohio Cir.Ct.R.,N.S., 151 (1909)

Bridge v. Ohio, 20 Ohio Cir.Ct.R.,N.S., 231 (1912)

Ohio v. Holden, 20 Ohio N.P.,N.S., 200 (1917)



I. I. ROSEN, M.D., Plaintiff,
v.
The LOUISIANA STATE BOARD OF MEDICAL EXAMINERS, Defendant.
Civ. A. No. 70-1304.

United States District Court,
E. D. Louisiana,
New Orleans Division.
Aug. 7, 1970.

Suit by physician seeking injunction restraining Louisiana State Board of Medical Examiners from enforcing, in proceedings being brought against him, statute authorizing removal of physician's certification for procuring, aiding, or abetting in procuring an abortion, unless done for the relief of woman whose life appears in peril, after due consultation with another licensed physician, and seeking judgment declaring such statute unconstitutional. The three-judge District Court, Ainsworth, Circuit Judge, held that it is the policy of the Louisiana abortion statutes that whatever interests the pregnant woman or others may have in terminating pregnancy must, except where life of the woman is threatened, be subordinated to afford embryo or fetus opportunity to develop toward natural birth, that Louisiana was empowered to place such value upon prenatal life, and that the statute in question is necessary to accomplishment of such permissible state policy and does not offend due-process clause of the Fourteenth Amendment.

Suit dismissed.

Cassibry, District Judge, dissented and filed opinion.

1. Courts ⇐268.4

Abstention was not warranted in suit wherein physician, against whom charges had been brought before Medical Board with respect to alleged illegal abortions, was seeking declaration that statute authorizing suspension or revocation of physician's certificate, when he has committed or participated in commission of abortion that is unnecessary to relief of woman whose life appears in peril, was unconstitutional. LSA-R.S. 37-1285(6).

2. Statutes ⇐47

Louisiana statute authorizing suspension or revocation of medical doctor's certificate when doctor has committed or participated in commission of abortion "unless done for the relief of a woman whose life appears in peril" is not unconstitutionally vague or indefinite. LSA-R.S. 37:1285(6).

3. Abortion ⇐2

Louisiana law does not suffer performance of all medically indicated abortions, but permits induced abortion of embryo or fetus only when the physician, after due consultation with another licensed physician, determines in good faith that continuation of the pregnancy will itself directly and proximately result in the death of the woman. LSA-R.S. 37:1285(6).

4. Constitutional Law ⇐82

Right of women to determine, before they have become pregnant, whether they shall bear children, may be interfered with by state only in special circumstances, but such right does not compel conclusion that woman has right to cause abortion of embryo or fetus carried by her.

5. Physicians and Surgeons ⇐4, 11(2)

In Louisiana, conviction of crime, including crime of abortion as proscribed in the criminal laws, and procuring, aiding or abetting in procuring abortion unless done to save the life of the mother are separate grounds upon which Medical Board may properly refuse to issue or may suspend or institute proceedings to revoke certificate to practice medicine to which physician would otherwise be entitled. LSA-R.S. 14:87, 37:1285(1, 6).

6. Abortion ⇐1

Louisiana law prohibits performance of certain acts if made with intent to destroy embryo or fetus before nat-

ural birth, without regard to viability, unless the actor is a physician and the acts are performed for the relief of a woman whose life appears in peril. LSA-R.S. 14:87, 37:1285(6).

7. Abortion ⇐1

As used in Louisiana statute proscribing abortion terms "embryo" and "fetus" refer to separate stages in prenatal development. LSA-R.S. 14:87.

8. Abortion ⇐3

In Louisiana, woman who procures abortion for herself is not criminally responsible. LSA-R.S. 14:87.

9. Abortion ⇐1

Though Louisiana has demonstrated greater concern for life after birth than for life before birth, it is the policy of the Louisiana abortion statute that whatever interests the pregnant woman or others may have in terminating pregnancy must be subordinated, except where the life of the woman is threatened, to afford the embryo or fetus the opportunity to develop toward natural birth. LSA-R.S. 14:87, 37:1285(6).

10. Abortion ⇐1

Louisiana has sufficiently manifested its interest in protecting the embryo or nonviable fetus that statute penalizing physician for procuring abortion except where woman's life appears to be in peril cannot be voided on the ground that the only legitimate purpose for which it was enacted was to protect lives and health of pregnant women and that, in view of advances in medical knowledge and surgical techniques, it is no longer wise legislation. LSA-R.S. 37:1285(6).

11. Constitutional Law ⇐38

Constitutional validity of statutes does not turn upon whether legislators have manifested their intent that the inevitable effect of such statutes, as viewed on their face, was meant to occur.

12. Constitutional Law ⇐70(3)

Federal courts will not strike down otherwise constitutional statute on basis of alleged wrongful legislative motive.

13. Constitutional Law ⇐70(3)

Federal courts will not void legislation which state had power to enact on more than one ground because the alleged dominant motive behind the statute is no longer served by its application.

14. Abortion ⇐1
Courts ⇐262.4(6)

Louisiana was empowered to place value upon prenatal human life, and such valuation, as manifested by its abortion statutes, could not be struck down by federal court. LSA-R.S. 14:87, 37:1285(6).

15. Courts ⇐262.4(5)

Review of state legislation by federal courts, whether such legislation is in exercise of state's police power or in provision for health, safety morals, or welfare of its people, concerns powers of government inherent in every sovereignty.

16. Constitutional Law ⇐81

Term "police power" connotes time tested conceptual limit of public encroachment upon private interests, and the definition thereof is essentially the product of legislative determination addressed to the purposes of government, which are themselves not capable of complete definition.

See publication Words and Phrases for other judicial constructions and definitions.

17. Courts ⇐262.4(5)

Federal courts may interfere with exercise of the plenary power of state governments in enactment of legislation only to the extent that the Constitution so requires.

18. Courts ⇐89

Principles of a judicial decision, while tending to expand themselves to the limits of their logic, must be contained by the historical frame of reference of their purpose.

19. Constitutional Law ⇐70(3)

Even where social undesirability of law is not disputed, invalidation of that

law by a court debilitates popular democratic government.

20. Constitutional Law ⇐82

Conclusion that pregnant woman's interests are superior to that of an unquickened embryo is not mandated by the Constitution.

21. Abortion ⇐1

The Louisiana abortion laws do not infringe any fundamental principle as understood by the traditions of our people. LSA-R.S. 14:87, 37:1285(6).

22. Constitutional Law ⇐81

Mere assertion that action of state finds justification in the realm of morals cannot justify any and every restriction it imposes.

23. Constitutional Law ⇐82

Asserted right of woman to choose to destroy embryo or fetus she carries is not so rooted in the traditions and collective conscience of our people that it must be ranked as fundamental.

24. Constitutional Law ⇐287
Physicians and Surgeons ⇐2

Louisiana statute providing that Medical Board may refuse to issue and may suspend or institute proceedings to revoke certificate to practice medicine if physician procures, aids, or abets in procuring an abortion, unless done for relief of woman whose life appears in peril after due consultation with another licensed physician, is necessary to the accomplishment of permissible state policy, and does not offend the due-process clause of the Fourteenth Amendment. LSA-R.S. 37:1285(6); U.S.C.A.Const. Amend. 14.

Roy Lucas, New York City, Benjamin E. Smith, Smith & Scheuermann, New Orleans, La., for plaintiff.

Sam A. LeBlanc III, Adams & Reese, New Orleans, La., for defendant.

Before AINSWORTH, Circuit Judge, and CASSIBRY and BOYLE, District Judges.

AINSWORTH, Circuit Judge:

Isadore I. Rosen, a physician licensed to practice medicine under the laws of Louisiana, challenges the constitutionality of the Louisiana statute authorizing the suspension or revocation of a medical doctor's certificate when the doctor has committed or participated in the commission of an abortion that is unnecessary to the relief of a woman whose life appears in peril. He seeks an injunction restraining the Louisiana State Board of Medical Examiners (Medical Board) from enforcing La.Rev.Stat.Ann. § 37:1285 in proceedings being brought against him and a judgment declaring section 37:1285(6) unconstitutional.

This three-judge district court was convened to consider the issues raised by Dr. Rosen's complaint, 28 U.S.C. § 2281, and a hearing was held on the merits of the case. We hold that section 37:1285(6) is constitutional and deny plaintiff's request for declaratory and injunctive relief.

I.

The Louisiana Medical Practice Act, La.Rev.Stat.Ann. § 37:1261 *et seq.*, authorizes the Medical Board to suspend or institute court proceedings to revoke a doctor's certificate to practice medicine in the State when the doctor has procured or aided or abetted in the procuring of an abortion, "unless done for the relief of a woman whose life appears in peril after due consultation with another licensed physician." La.Rev.Stat. Ann. § 37:1285(6). On November 12, 1969, the Medical Board informed Dr. Rosen of its intent to conduct a hearing on charges that Dr. Rosen has on several occasions committed or aided in the commission of abortions without legal justification for so doing. A hearing was originally scheduled for December 12, 1969. This lawsuit followed. We have jurisdiction to decide the case. *E. g.*, Roe v. Wade, N.D.Tex., 1970, 314 F. Supp. 1217; Babbitz v. McCann, E.D. Wis., 1970, 310 F.Supp. 293.

[1] The complaint charges that section 37:1285(6) of the Louisiana Revised Statutes is unconstitutional for violating the First, Fourth, Fifth, Ninth, and Fourteenth Amendments to the United States Constitution and for invading the pregnant woman's right of privacy. The Medical Board argues initially that this Court should abstain from making a decision on the merits of plaintiff's request for a declaratory judgment. Under the circumstances of this case, we conclude that abstention would not be warranted. *See, e. g.*, Zwickler v. Koota, 389 U.S. 241, 88 S.Ct. 391, 19 L.Ed.2d 444 (1967); Roe v. Wade, N.D. Tex., 1970, 314 F.Supp. 1217; Babbitz v. McCann, E.D.Wis., 1970, 310 F. Supp. 293. We therefore reach the merits of Dr. Rosen's argument. For reasons that follow, we conclude that the doctor's attack upon the constitutionality of section 37:1285(6) must fail.

II.

The doctor urges that section 37:1285 (6) of the Louisiana Revised Statutes is unconstitutionally vague and indefinite because it fails to provide both fair warning to doctors and sufficient precision to guide the Medical Board, judges, and juries regarding the physical or mental conditions that justify an induced abortion under Louisiana law. This section provides for the removal of a physician's certification for "[p]rocuring, aiding, or abetting in procuring an abortion unless done for the relief of a woman whose life appears in peril after due consultation with another licensed physician." Rosen argues that the words "relief of a woman whose life appears in peril" do not provide meaningful guidance to the ordinary physician since the statute forbids abortions in terms "so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application." Connally v. General Construction Co., 269 U.S. 385, 391, 46 S.Ct. 126, 127, 70 L.Ed. 322 (1926); *accord*, Lanzetta v. State of New Jersey, 306 U.S. 451, 59 S.Ct. 618, 83 L.Ed. 888 (1939). He also argues that uncertainty in the medical profession regarding the legality of certain medically indicated abortions is a constitutional defect in the statute as applied.

[2, 3] We have examined the challenged language and are persuaded that it is neither vague nor indefinite, but is instead reasonably comprehensible in its meaning, with its reach delineated in words of common understanding. *See* Babbitz v. McCann, E.D.Wis., 1970, 310 F.Supp. 293, 297–298; *cf.* Cameron v. Johnson, 390 U.S. 611, 616, 88 S.Ct. 1335, 1338, 20 L.Ed.2d 182 (1968). The clause "unless done for the relief of a woman whose life appears in peril" requires no guessing at its meaning. Rosen focuses upon the words "relief," "appears," and "life." These are widely used and well understood words, particularly when read in the context of section 37:1285(6). We conclude that the statute was intended to permit an induced abortion of an embryo or fetus only when the physician, after due consultation with another licensed physician, determines in good faith that continuation of the pregnancy will directly and proximately result in the death of the woman. In our opinion, the statute so read provides fair warning that Louisiana does not suffer the performance of all medically indicated abortions, however wise in the physician's estimation such an operation might be in a particular case, but rather allows the induced abortion of an embryo or fetus to be performed without sanction only when the life of the mother is directly endangered by the condition of pregnancy itself.

Four recent cases dealing with the constitutionality of abortion statutes have considered the sort of void-for-vagueness argument that Rosen makes against the Louisiana statute. In People v. Belous, 71 Cal.2d 996, 80 Cal.Rptr. 354, 458 P.2d 194 (1969), the California Supreme Court found that the words "necessary to preserve her life" in the California abortion statute then in effect were unconstitutionally vague. The

words "for the purpose of saving the life of the mother" in the Texas abortion statute were declared to be similarly defective by a three-judge district court in Roe v. Wade, N.D.Tex., 1970, 314 F. Supp. 1217. The District of Columbia abortion statute was held invalid in United States v. Vuitch, D.D.C., 1969, 305 F.Supp. 1032, on the ground that the word "health" in the phrase "as necessary for the preservation of the mother's life or health" was vague both in interpretation and practice. The words "necessary to save the life of the mother" in the Wisconsin abortion statute, on the other hand, were held not to be vague or indefinite as to their meaning in Babbitz v. McCann, E.D.Wis., 1970, 310 F.Supp. 293.

Like the *Babbitz* court, we do not share the view of the majority in *Belous* that language such as "necessary to preserve [or save] life" is so vague that one must guess at its meaning. *See generally* Comment, To Be or Not to Be: The Constitutional Question of the California Abortion Law, 118 U.Pa.L.Rev. 643, 644–649 (1970). Consequently, *Belous* is not persuasive on the issue of vagueness presented in this case. We also do not share the view of the court in *Roe* that a statute worded similarly to either the Texas or Louisiana acts is unconstitutionally vague because of the difficulty encountered in applying it to particular cases. As the Supreme Court has stated,

> "Wherever the law draws a line there will be cases very near each other on opposite sides. The precise course of the line may be uncertain, but no one can come near it without knowing that he does so, if he thinks, and if he does so, it is familiar to the criminal law to make him take the risk."

United States v. Wurzbach, 280 U.S. 396, 399, 50 S.Ct. 167, 169, 74 L.Ed. 508 (1930); *see* United States v. Petrillo, 332 U.S. 1, 7, 67 S.Ct. 1538, 1541–1542, 91 L.Ed. 1877 (1947). Moreover, the Louisiana statute makes express what is perhaps only implied in the Texas statute—that the abortion need only *appear* necessary, rather than actually be necessary to be permissible. *Vuitch* is readily distinguishable from the present case, since the court there concluded that the word "health," as distinct from the word "life," made the District of Columbia statute impermissibly vague. Thus the precise problem considered in *Vuitch* is not presented under the terms of the Louisiana statute.

In short, we conclude that although Rosen may have medical or even practical justification for his belief that the Louisiana statute too narrowly restricts the circumstances under which an abortion may be induced without sanction, he fails to convince this Court that the Louisiana Legislature was vague or indefinite in its choice of language.

III.

The doctor next contends that the Louisiana statute, even if assumed not to be lacking in either clarity or precision, is void for "overbreadth," that is, section 37:1285(6) offends the constitutional principle that "a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms." Zwickler v. Koota, 389 U.S. 241, 250, 88 S.Ct. 391, 396, 19 L.Ed.2d 444 (1967), *citing* NAACP v. Alabama ex rel. Flowers, 377 U.S. 288, 307, 84 S.Ct. 1302, 1314, 12 L.Ed.2d 325 (1964). Rosen argues that the statute unnecessarily and impermissibly invades his right as a physician to prescribe for his patients in accordance with his best professional knowledge. Specifically, he contends that the statute makes removal of his license a likelihood if, in the course of performing his duties as a physician, he assists a pregnant woman —who has had contraceptive failure or did not utilize contraceptives—in the exercise of what he asserts to be her fundamental, constitutionally protected right to choose whether to bear children. In substance, his argument is that: (1) a woman has a fundamental right, ex-

cept in very limited circumstances, to be free from unwanted governmental interferences in matters that, by their character and consequences, bear in a basic way upon her privacy, that is, she has a right to be let alone in matters involving her individual privacy; (2) included within her right to be let alone is her right to choose whether to bear children; (3) since the Louisiana statute infringes upon her right of choice in this matter and operates directly upon the physician's role in the effective exercise of that choice, the statute may be upheld by this Court only upon a showing by the State that such infringement is necessary to support a subordinating state interest which is compelling; and (4) the Louisiana statute sweeps far beyond any areas of compelling, subordinating state interests and is, therefore, invalid. Thus the doctor would have us first determine whether the right to choose to bear or not to bear, children is a fundamental one and then determine whether, if this is a fundamental right, the State has demonstrated a compelling need to infringe upon its exercise.

In our opinion, the issues in dispute here do not resolve themselves neatly into the questions posed by Dr. Rosen. The issues presented are much more complex, for the current controversy over the wisdom and constitutional validity of existing abortion laws centers upon a problem in which attitudes toward life, being, and sexual activity are in tumultuous disagreement. The specifics of the conflict in courts, legislative halls, and journals have often been the details of statutory language. The root disagreement, however, among men of intelligence and good will on all sides of the controversy has arisen over the evaluation of competing interests affected by abortion and the manner in which these interests are to be protected by law in a democratic society. *See generally* George, Current Abortion Laws: Proposals and Movements for Reform, in Abortion and the Law 1 (Smith ed. 1967); Ziff, Recent Abortion Law Reforms (Or Much Ado About Nothing), 60 J.Crim.L.C. & P.S. 3 (1969). Nature alone is responsible for the spontaneous abortion, and she needs no justification. But there remains for the determination by society, by whatever means it has chosen for the making of such momentous decisions, the conditions, if any, under which the embryo or fetus of the species homo sapiens may be destroyed within the womb.

The most recent attacks on abortion legislation, like Dr. Rosen's, have focused upon the interests of the pregnant woman as being of primary importance. The interests of the family unit, if any, of which the pregnant woman is a part and the needs of the community have also been advanced as reasons for the relaxation or abolition of laws prohibiting abortions. Little or no importance has been attached by these arguments to whatever interests may be possessed by the embryo or fetus the pregnant woman carries. In at least four instances, arguments such as these have been urged successfully. Roe v. Wade, N.D.Tex., 1970, 314 F.Supp. 1217; Babbitz v. McCann, E.D.Wis., 1970, 310 F.Supp. 293; People v. Belous, 71 Cal.2d 996, 80 Cal.Rptr. 354, 458 P.2d 194 (1969); State v. Munson (S.D.Cir.Ct., Pennington County, April 6, 1970). *See also* United States v. Vuitch, D.D.C., 1969, 305 F.Supp. 1032. In all these cases, the right asserted by plaintiffs to be free from unwanted governmental interference—freedom of choice in the matter of abortions—was equated by the court with the "fundamental right to choose whether to have children."

[4] For the purposes of this case we assume, if we are not required to recognize, *e. g.*, Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965); Baird v. Eisenstadt, 1 Cir., 1970, 429 F.2d 1398, that as a general matter women possess under our Constitution a "fundamental right" to determine whether they shall bear children before they have become pregnant. A state may interfere with this right of choice only in special circumstances. *E.*

g., Buck v. Bell, 274 U.S. 200, 47 S.Ct. 584, 71 L.Ed. 1000 (1927). We deal in this case, however, not merely with whether a woman has a generalized right to choose whether to bear children, but instead with the more complicated question whether a pregnant woman has the right to cause the abortion of the embryo or fetus she carries in her womb. We do not find that an equation of the generalized right of the woman to determine whether she shall bear children with the asserted right to abort an embryo or fetus is compelled by fact or logic. Exercise of the right to an abortion on request is not essential to an effective exercise of the right not to bear a child, if a child for whatever reason is not wanted. Abstinence, rhythm, contraception, and sterilization are alternative means to this end. The first is, of course, infallible; the latter three are reliable to varying degrees approaching certainty. Before the "moment" of conception has occurred, *see generally* Ziff, Recent Abortion Law Reforms (Or Much Ado About Nothing), 60 J.Crim.L.C. & P.S. 3, 20–21 (1969), the choice whether or not to bear children is made in circumstances quite different from those in which such a choice might be made after conception. Apart, the sperm and the unfertilized egg will die; neither has the capacity to grow and develop independently as does the fertilized egg. During fertilization, sperm and egg pool their nucleii and chromosomes. Biologically, a living organism belonging to the species homo sapiens is created out of this organization. Genetically, the adult man was from such a beginning all that he essentially has become in every cell and human attribute. *See generally* Gray, Anatomy of the Human Body 21–60 (Goss 27th ed. 1959); 5 Lawyers' Medical Cyclopedia § 37.1 (1960). The basic distinction between a decision whether to bear children which is made before conception and one which is made after conception is that the first contemplates the creation of a new human organism, but the latter contemplates the destruction of such an organism already created. To some engaged in the controversy over abortion, this distinction is one without a difference. These men of intelligence and good will do not perceive the human organism in the early part of its life cycle as a human "being" or "person." [1] In their view, the granting to such an organism of the right to survive on a basis of equality with human beings generally should be delayed until a later stage in its development. To others, however, the "moment" of conception or some stage of development very close to this "moment" is the point at which distinctively human life begins.[2] In their view the difference be-

1. The views following are illustrative:
"My feeling is that the fetus, particularly during its early intra-uterine life, is simply a group of specialized cells that do not differ materially from other cells. * * * And I feel that if it is going to be for the welfare of the adult individual, and for society in certain instances, we are justified in eliminating those cells. I do not think that I could be catalogued as a murderer. I just feel that under certain conditions the elimination of life of this type is justified. If one can justify shooting a burglar who enters your room, or going to war and shooting an enemy, one can certainly justify the elimination of some cells, which, from my point of view, have not yet become a human being, but simply have the potentialities of life. * * *"
Statement of Dr. Alan F. Guttmacher, in Symposium—Law, Morality, and Abortion, 22 Rutgers L.Rev. 415, 436 (1968);
"* * * Physicians as a whole do not believe that a human being begins at conception. I know of no non-Catholic scientist who does. I know of no scientist at all, no scientist in any field of biological science, who would say that an acorn, the second that that acorn has been fertilized, is an oak. It is a potential oak; it is not an oak. And a fertilized ovum is not a human being. * * *"
Statement of Dr. Harold Rosen, in *id.* at 426.

2. For example, this is the official Roman Catholic position. E. g., Drinan, The Inviolability of the Right To Be Born, in Abortion and the Law 107 (Smith ed.

tween the decision not to conceive and the decision to abort is of fundamental, determinative importance. Thus the root problem in the controversy over abortion is the one of assigning value to embryonic and fetal life. *See* Giannella, The Difficult Quest for a Truly Humane Abortion Law, 13 Vill.L.Rev. 257 (1968).

In considering the problem of valuing prenatal life, we heed the words of Mr. Justice Holmes:

> "It is a misfortune if a judge reads his conscious or unconscious sympathy with one side or the other prematurely into the law, and forgets that what seem to him to be first principles are believed by half his fellow men to be wrong * * *."

Holmes, Collected Legal Papers 295 (1920). When distinctively human life begins is a matter about which reasonable, fair-minded men are in basic disagreement. Thus this case does not concern simply whether the pregnant woman has a fundamental right to be let alone in the control of her body processes, *cf.* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 11 S.Ct. 1000, 35 L.Ed. 734 (1891) (submission to surgical examination), for it is unresolved whether, in the common understanding of the society in which she lives, choice of the destiny of the human organism developing within her is a matter directly affecting only her individual rights. We phrase the question for decision as follows: Can the State of Louisiana, consistent with the Fourteenth Amendment, assign to the human organism in its early prenatal development as embryo and fetus a right to be "born"[3] unless the condition of pregnancy directly and proximately threatens the mother's life? Our inquiry extends to (1) whether, and the extent to which, the State has assigned value to prenatal life, (2) whether the State is empowered to make such an assignment, and (3) whether the State's valuation is to be recognized for the purposes of this case.

We consider first the pattern of the Louisiana statutes pertaining to abortion. In Louisiana, "abortion" has been a crime since 1870. The 1870 statute, as amended, La.Acts, 1888, No. 24, provided:

> "Whoever shall feloniously administer, or cause to be administered, any drug, potion, or any other thing, to any woman for the purpose of procuring a premature delivery, or whoever shall administer, or cause to be administered, to any woman pregnant with child, any drug, potion, or any other thing, for the purpose of procuring abortion or a premature delivery, or whoever by any means whatsoever shall feloniously procure abortion or premature delivery, shall be imprisoned at hard labor for not less than one nor more than ten years."

We have not been cited to or found any legislative history on this statute. As we read it, the statute made unlawful the described acts if performed with the specific intent to destroy a "child" before its natural birth, regardless of whether the woman was in fact pregnant; that is, attempts to perform the impossible were equated with and treated the same as actual performance. Reworded in 1942 and later amended, the statute reads today:

> "Abortion is the performance of any of the following acts, with the intent of procuring premature delivery of the embryo or fetus;
>
> (1) Administration of any drug, potion, or any other substance to a female; or
>
> (2) Use of any instrument or any other means whatsoever on a female.
>
> "Whoever commits the crime of abortion shall be imprisoned at hard labor for not less than one nor more than ten years."

1967); Statement of Thomas J. O'Donnell, S. J., in Symposium—Law, Morality, and Abortion, 22 Rutgers L.Rev. 415, 431–432 (1968).

3. As used here, the term "born" refers to delivery from the womb after the developing human organism is capable of sustaining life outside the womb. *See* La. Rev.Stat.Ann. § 40:142.

La.Rev.Stat.Ann. § 14:87 (Supp.1970). In substance, the Louisiana criminal law on abortion has been unchanged for one hundred years.[4]

[5–7] In Louisiana, conviction of a crime such as the crime of "abortion" proscribed by section 14:87, and procuring, aiding or abetting in procuring an "abortion" unless done to save the life of the mother are separate grounds upon which the Medical Board may properly refuse to issue, suspend, or institute court proceedings to revoke a certificate to practice medicine to which a physician would otherwise be entitled. La.Acts, 1914, No. 56, § 16, as amended, La.Acts, 1918, No. 54, § 10, codified, La.Rev.Stat. Ann. § 37:1285(1), (6). *See also* La. Rev.Stat.Ann. § 1271 (qualifications of applicants for certificates). Since sections 14:87 and 37:1285(6) deal with the same subject matter, we construe them together. So doing, we conclude that Louisiana prohibits the performance of certain acts if made with the intent to destroy an "embryo" or "fetus" before natural "birth," unless (1) the actor is a physician and (2) the acts are performed for the relief of a woman whose life appears in peril. As used in section 14:87, the terms "embryo" and "fetus" refer to separate stages in prenatal development. State v. Dore, 227 La. 282, 79 So.2d 309 (1955). In medical terminology, "embryo" refers to the developing human organism from one week after conception to approximately the end of the second month. "Fetus" refers to the organism from that point until termination of prenatal development. Dorland, Illustrated Medical Dictionary 439, 500 (23d ed. 1957).[5] From conception until the twentieth week of development, expulsion of the embryo or fetus from the womb is not considered by the State to be a "birth." La.Rev.Stat.Ann. § 40:-142(5).

[8, 9] From a reading of the Louisiana statutes, it is plain that the State has attempted to provide embryonic and fetal organisms with protection against destruction by other than natural causes in at least the second and succeeding weeks of prenatal development, without regard to whether the organism is capable of sustaining life outside the womb. This protection is qualified. The embryo or fetus may legally be destroyed by a physician if the condition of pregnancy, after due consultation with another licensed physician, appears directly and proximately to threaten the woman's life. Also, section 14:87, as construed, does not make the woman criminally responsible for the destruction of the embryo or fetus she once carried. *E. g.*, Simmons v. Victory Industrial Life Ins. Co. of Louisiana, 18 La.App. 660, 139 So. 68 (1932). With these qualifications, a principal effect of the Louisiana statutes has been a conferment upon the embryonic or fetal organism of a right to survive to a natural termination of prenatal development. Necessarily implicit in this conferment is a valuation of embryonic and fetal life in relation to the life of the infant, the child, and the adult. Regardless of whatever interests the pregnant woman or others may have in ending the life of the embryo or

4. Section 14:87 was amended in 1964 to provide, as did the 1870 statute, that commission of the crime of abortion does not depend upon whether the woman is actually pregnant, so long as the requisite unlawful intent is present. From 1942 until 1964, an attempt to perform an abortion on a woman who was not pregnant apparently was punishable as an "attempt," rather than as a crime of abortion.

5. Although Louisiana law is clear to the effect that "embryo" and "fetus" refer to separate stages of prenatal development, there is no Louisiana law on the question whether "embryo," as used in section 14:87, refers to the "zygote" as well as to the "embryo," as used in medical terminology. If the statute uses "embryo" in its technical medical sense, the induced expulsion of the "zygote" from the womb in the first week of development would not be an "abortion" under section 14:87, because the section deals with the "embryo" and the "fetus." We note this question without comment since its resolution is unnecessary to the disposition of this case.

fetus she carries, application of the Louisiana statutes, subject to the above qualifications, results in the subordination of such interests to the policy of the State that prenatal life must be afforded the opportunity to develop toward a natural birth.

[10] In medical terminology, "abortion" generally refers to the premature expulsion from the womb of the embryo or of the nonviable fetus. Dorland, Illustrated Medical Dictionary 4 (23d ed. 1957). As indicated, the Louisiana statutes make no distinction based upon viability in defining "abortion," that is, upon whether the fetal organism has developed to the stage in which it can sustain life outside the womb or, in the terminology adopted by the State, be "born." *See* La.Rev.Stat.Ann. § 40:142(5). Dr. Rosen argues that Louisiana has not expressed a policy of preferring the interests of an embryo or nonviable fetus as a "human being" over those of the pregnant woman, family unit, or community. To the contrary, he claims, Louisiana has expressed no interest in the embryo or nonviable fetus. Also, he urges that section 37:1285(6) is unconstitutional because the only "legitimate" purpose for which it, like the 1870 criminal statute and its successors, could have been enacted—protection of the lives and health of pregnant women—is no longer served by its application. Not persuaded by these arguments, we conclude that Louisiana has sufficiently manifested its interest in protecting the embryo or nonviable fetus and that section 37:1285(6) cannot be voided essentially on the ground that it is no longer wise legislation.

The inevitable effect of the Louisiana statutes in question is to accord embryonic and fetal human life qualified protection against premeditated destruction by persons other than the mother. As we have said, implicit in this affording of protection is the assignment of value to the embryonic or fetal organism as a form of human life. "Subject to specific constitutional limitations, when the legislature has spoken, the public interest has been declared in terms wellnigh conclusive."[6] Berman v. Parker, 348 U.S. 26, 32, 75 S.Ct. 98, 102, 99 L.Ed. 27 (1954). In our opinion, the State of Louisiana values embryonic or fetal human organisms to the extent that such organisms—forms of human life—are entitled to enjoy in at least some basic respects the right to survive on a basis of equality with human beings generally.

As we have indicated, the protection afforded by Louisiana to the embryo or fetus is not coextensive with the protection afforded to the infant, the child,

6. The abortion statutes are not the only laws in which Louisiana has manifested its concern with the problem of valuing prenatal life. In Louisiana, "Children in the mother's womb are considered, in whatever relates to themselves, as if they were already born; thus the inheritances which devolve to them before their birth, and which may belong to them, are kept for them, and curators are assigned to take care of their estates for their benefit." La.Civ.Code Ann. art. 29. In the matter of successions, for example, the "child in its mother's womb is considered as born for all purposes of its own interest; it takes all successions opened in its favor since its conception, provided it be capable of succeeding at the moment of its birth." La.Civ.Code Ann. art. 954. It is true, as Dr. Rosen points out, that the right to inherit vests only in children born alive, regardless of the mode of birth and the length of life after birth. La.Civ. Code Ann. arts. 956, 957, and "Children born dead are considered as if they had never been born or conceived." La.Civ. Code Ann. art. 28. From this the doctor argues that the abortion of an embryo or nonviable fetus would do no violence to the existing Louisiana law of successions. *See* Comment, Abortion and the Law: A Proposal for Reform in Louisiana, 43 Tul.L.Rev. 834, 850–851 (1969). Whether this argument is correct or not is beside the point. Read together, the abortion and succession statutes manifest a coherent policy: The "child in its mother's womb" (embryo or fetus) is afforded certain rights by the State, the enjoyment of which vests upon live birth; the abortion statutes afford the embryo or fetus a qualified opportunity to be born alive in order to enjoy rights such as that of inheritance.

and the adult. Historically and today, the State has demonstrated a greater concern for life after birth than for life before birth. For example, although Louisiana early adopted the common law as to the definition of crimes, La.Acts, 1805, No. 50, § 33, and abortions were not permitted at common law after fetal "quickening," *see, e. g.*, Stern, Abortion: Reform and the Law, 59 J.Crim.L. C. & P.S. 84, 85 (1968),[7] the principle that all crimes in Louisiana are statutory, *e. g.*, State v. Williams, 7 Rob. 252 (La.1844), meant that abortion was not a crime in this State until the 1870 statute was enacted. In terms of punishment and criminal responsibility also, the State has not equated the destruction of an embryo or fetus with the destruction of an infant, a child, or an adult. For example, the pregnant woman who causes the abortion of the "child" in her womb is not made criminally responsible, and those to whom she turns for an abortion may be imprisoned for no more than ten years for the offense. The mother who causes the death of her infant child, on the other hand, may be convicted of murder, manslaughter, or negligent homicide, as the case may be, with death as the ultimate penalty. La.Rev.Stat.Ann. §§ 14:30–32. These facts suggest, for example, that Louisiana does not equate the equality of the offense of "murder," La.Rev.Stat.Ann. § 14:30, with the quality of an act of abortion. In no meaningful way, however, do they rebut the Medical Board's contention that, for the past century, the State in its abortion laws has manifested a policy of protecting human life in its embryonic and fetal forms.[8]

Dr. Rosen argues that the purpose of the Louisiana abortion statutes—other than to compel adherence to specified moral norms[9]—is to protect the lives and health of women who believe themselves to be pregnant rather than to protect the embryo or fetus from destruction. Notwithstanding that these laws, when obeyed, do protect the embryo or fetus, it is suggested that, in light of the pattern of the Louisiana statutes and the history of abortion and the law generally, the Louisiana laws are, at best, health measures that no longer promote good health.[10]

[11–14] We decline to void section 37:1285(6) essentially on the ground that advances in medical knowledge and surgical techniques have made unwise

7. *See also* 3 Coke, Third Inst. 50 (1797); 1 Blackstone, Commentaries Comm. 1, 129–130 (4th ed. 1771); Perkins, Criminal Law 101 (1957).

8. In Louisiana, "homicide" is the killing of a "human being," and criminal homicide is either murder, manslaughter, or negligent homicide. La.Rev.Stat.Ann. § 14:29. Since the destruction of an embryo or fetus is not a homicide under Louisiana law, it has been argued that the State does not consider embryonic and fetal life forms as "human beings." Though destruction of an embryo or fetus under Louisiana law is not considered a homicide so that the perpetrator of its destruction is punishable as a "murderer," it does not follow from the principle that "murder" and "abortion" are distinct crimes under state law that the Louisiana Legislature did not consider embryo and fetus as forms of human life. We may not ascribe to the legislature ignorance of biological realities, nor should we, at the same time, require its express manifestation that it was aware of these realities.

9. The enactment of abortion legislation in the last century has been attributed to the influences of "comstockery." 5 Harv. Civ.Rights-Civ.Lib.L.Rev. 133, 144 (1970). Anthony Comstock, who inspired the use of the opprobrious word "comstockery," was, of course, a man to whom obscenity was "poison to soul and body, and anything remotely touching upon sex was * * * obscene." Broun & Leech, Anthony Comstock 265–266 (1927), *in* Poe v. Ullman, 367 U.S. 497, 520 n. 10, 81 S.Ct. 1752, 1764–1765 n. 10, 6 L.Ed. 2d 989 (1961) (Brennan, J., concurring).

10. *See, e. g.*, Tietze, Mortality With Contraception and Induced Abortion, 45 Studies in Family Planning 6 (1969); Tietze, Abortion Laws and Abortion Practices in Europe, Excerpta Medica International Congress Series No. 207 (1969); People v. Belous, 71 Cal.2d 954, 965, 80 Cal.Rptr. 354, 361, 458 P.2d 194, 201 (1969).

legislation which the State of Louisiana had the power to enact, and we do not believe that the constitutional validity of statutes turns upon whether legislators make speeches or otherwise manifest their intent that the inevitable effect of statutes, viewed on their face alone, was indeed meant to occur. It is a familiar principle of constitutional law that the federal courts will not strike down an otherwise constitutional statute on the basis of an alleged wrongful legislative motive. *E. g.*, United States v. O'Brien, 391 U.S. 367, 383, 88 S.Ct. 1673, 1682, 20 L.Ed.2d 672 (1968); McCray v. United States, 195 U.S. 27, 56, 24 S.Ct. 769, 776, 49 L.Ed. 78 (1904). Similarly, the federal courts will not void legislation which a State had the power to enact on more than one ground because the alleged dominant motive behind the statute is no longer served by its application. In this case, we hold that the State of Louisiana was empowered to place a value upon prenatal human life and that the valuation manifested by the Louisiana abortion statutes may not be struck down by this Court.

At issue here is whether the Louisiana abortion statutes, in assigning a value to prenatal life relative to the interests of the pregnant woman, her family unit, if any, and the community, have invaded a realm of private morality which is not the State's business. *Compare* Committee on Homosexual Offenses & Prostitution (Wolfenden Committee), Report, CMD. No. 247, ¶ 62 (1957).[11] The crime of abortion in Louisiana is classified together with carnal knowledge of, or indecent behavior with, juveniles, prostitution, and the "crime against nature" as "offenses affecting sexual morality."[12] To many in Louisiana, as in other states, a woman who voluntarily causes an abortion of the embryo or fetus she carries "is guilty of a detestible and revolting offense against the laws of nature, which is universally condemned." Payne v. Louisiana Industrial Life Ins. Co., 33 So.2d 444, 445 (La.Ct.App.1948). *See also, e. g.*, Mills v. Commonwealth, 13 Pa. 631, 632 (1850). To others like Dr. Rosen, on the other hand, the failure to limit procreation by abortion is itself unconscionable and immoral if, for example, offspring are destined to be physically or mentally deformed in some fundamental way, to be undernourished, maleducated misfits or rebels against society, or to be unwanted or not cared for because of the economic, physical, and psychological dislocations their births and rearing cause in their parents' lives. We must ask whether abortion, a problem in which attitudes toward life, being, and sexual activity are in such turmoil, is the business of government and the law.

[15–17] The review of state legislation by the federal courts, whether such legislation is considered to be in the exercise of the State's police power or in provision for the health, safety, morals, or welfare of its people, concerns the "powers of government inherent in every sovereignty." The License Cases, 46 U.S. (5 How.) 504, 583, 12 L.Ed. 256, 291 (1847); Poe v. Ullman, 367 U.S. 497, 539, 81 S.Ct. 1752, 1775, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting). The definition of a State's police power is "essentially the product of legislative determinations addressed to the purposes of government, purposes neither abstractly nor historically capable of complete definition." Berman v. Parker, 348 U.S. 26, 32, 75 S.Ct. 98, 102, 99 L.Ed. 27 (1954). The term "police power" connotes the "time-tested conceptual limit of public encroachment upon private interests." Goldblatt v. Town of Hempstead, N.Y., 369 U.S. 590, 594, 82 S.Ct. 987, 990, 8 L.Ed.2d 130 (1962). The federal courts may interfere with

11. *See also* Devlin, The Enforcement of Morals 1–25 (1965); Sutherland, Constitutionalism in America 527–536 (1965); Henkin, Morals and the Constitution: The Sin of Obscenity, 63 Colum.L.Rev. 391 (1963); Schwartz, Morals Offenses and the Model Penal Code, 63 Colum.L.Rev. 669 (1963).

12. La.Rev.Stat.Ann. §§ 14:80–89.

the exercise of this plenary power of government by the States only to the extent that the Constitution so requires. Barron, for Use of Tiernan v. Mayor and City Council of Baltimore, 32 U.S. (7 Pet.) 243, 8 L.Ed. 672 (1833).

The abortion problem concerns the circumstances, if any, that justify the termination of the process of procreation after human life, genetically and biologically, has been conceived. This problem involves the condition of pregnancy and its likely consequence, the first entrance of a new player, "mewling and puking," onto the world stage. Shakespeare, As You Like It, Act ii, sc. 7, l. 139. In specific cases, the condition of pregnancy, if not terminated, may affect the essential welfare of the woman involved; it may cause her to die before her time, to suffer a serious impairment of her health, to waste her life, to be deeply unhappy, or to be happy in a way that society considers to be less than human.[13] Similarly affected may be the essential welfare of the unwanted player once born and the family into which it is born. If the healthy society is viewed as one that not only maintains itself as a going concern, but also, through its free and democratic character, moves in the direction of giving greater scope and expression to those wholesome attributes that set man above the lower species, it may be seen that the abortion problem, if not wisely handled, may in the end impair the good health of the society. But federal judges are not inevitably the source of the wise solution. Under our Constitution, federal judges play a limited role in reviewing the legislation of Congress and the States. We believe that if the passage of a law or a failure to effect its repeal "has ruined a state, there was a general cause at work that made the state ready to perish by a single * * * law." Holmes, Collected Legal Papers 295 (1920). Thus we view the Louisiana abortion laws.

At least with respect to abortion, as medically defined, in the early, nonviable stages of development, proponents of the abolition or "liberalization" of abortion laws have in the main taken as their premise that distinctively human life, that is, valued life, does not commence at conception or at some point near it, but instead at some later stage of prenatal development, such as the point of viability, or at birth itself. Opponents of abolition or "liberalization" have argued from quite different premises. On balance, when "distinctively human" life begins is a matter of contest not so much between those persons and groups who see an embryo or fetus as a human being and those who do not, although this too is involved, but rather is a matter of contest between conflicting views regarding the importance of mere existence in relation to a high quality or excellence of existence.[14] In other words, proponents of abolition or "liberalization" have tended to stress the quality of life after birth rather than the mere existence of life, while their opponents have argued for the transcendence of any life, born or unborn, over the health or happiness of an older or more powerful life. Thus abortion, involving as it does the destruction of, biologically and genetically speaking, a form of human life, raises a basic issue of public interest concerning the value of the human embryo or fetus.

[18] In Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), the Supreme Court struck down a state statute forbidding the use of contraceptives because the law was found to operate unjustifiably upon one aspect of the intimate relation of husband and wife. From this is largely drawn by

13. The concepts of "essential welfare" and of the "healthy society" mentioned here are taken from Banfield, The Unheavenly City, 10–11 (1968).

14. *See generally* Drinan, The Morality of Abortion Laws, in Symposium—Abortion Law Reform, 14 Catholic Lawyer 180 (1968); Jakobovits, Jewish Views on Abortion, in Abortion and the Law 142 (Smith ed. 1967).

Dr. Rosen the argument that a fundamental right of women to choose whether to bear children, after as well as before conception has occurred, must be recognized. In *Griswold*, however, the Court was not required to sit as a super-legislature or rove at large in light of personal and private notions to conclude that choice in the matter of contraceptives was part of the rights associated with home, family, and marriage, which rights were supported by precedent, history, and common understanding.[15] The decision thus operates within a narrow sphere, *see* Kauper, Penumbras, Peripheries, Emanations, Things Fundamental and Things Forgotten: The Griswold Case, 64 Mich.L.Rev. 235 (1965); its principles, while tending to expand themselves to the limit of their logic, Cardozo, The Nature of the Judicial Process 51 (1921), must be contained by the historical frame of reference of their purpose. Walz v. Tax Commission of City of New York, 397 U.S. 664, 678–679, 90 S.Ct. 1409, 1416, 25 L.Ed.2d 697 (1970). In our opinion, whether the problem of abortion is a private one of personal or family morality requires first a resolution of the issue of public concern, that is, whether embryonic and fetal organisms should be afforded an opportunity to survive in at least some basic respects on a basis of equality with human beings generally.

[19, 20] Dr. Rosen has strenuously urged before this Court the social undesirability of the Louisiana abortion laws. We may not, however, while professing to act in the service of humane ends, confound private notions with constitutional imperatives. Even where the social undesirability of a law is not disputed, and this is by no means such a case,[16] invalidation of that law by a court debilitates popular democratic government. American Fed. of Labor v. American Sash & Door Co., 335 U.S. 538, 553, 69 S.Ct. 258, 265, 93 L.Ed. 222 (1949) (Frankfurter, J., concurring). We do not share the views of the Courts in Babbitz v. McCann, E.D.Wis., 1970, 310 F.Supp. 293, and Roe v. Wade, N.D.Tex., 1970, 314 F.Supp. 1217, regarding the criteria to be used in testing the constitutionality of abortion legislation. In *Babbitz*, for example, the Court, holding that the State of Wisconsin had not

15. For example, the Court had previously held that the liberty entitled to protection under the Fourteenth Amendment includes the right "to marry, establish a home and bring up children," Meyer v. State of Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (1923), and the "liberty of parents and guardians to direct the upbringing and education of children under their control." Pierce v. Society of the Sisters of the Holy Names, etc., 268 U.S. 510, 534–535, 45 S.Ct. 571, 573, 69 L.Ed. 1070 (1925). In Skinner v. State of Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942), the Court struck down an Oklahoma statute providing for the compulsory sterilization of "habitual criminals" on the ground that the statute invidiously discriminated between persons who had committed intrinsically the same quality of offense by sterilizing the one and not the other. To emphasize its view that "strict scrutiny of the classification which a State makes in a sterilization law is essential," the Court noted that it dealt "with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race. The power to sterilize, if exercised, may have subtle, far-reaching and devastating effects. * * *" 316 U.S. at 541, 62 S.Ct. at 1113. Finally, in Prince v. Commonwealth of Massachusetts, 321 U.S. 158, 166, 64 S.Ct. 438, 442, 88 L.Ed. 645 (1944), the Court stated:

> "It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder. Pierce v. Society of Sisters, supra. And it is in recognition of this that these decisions have respected the private realm of family life which the state cannot enter."

16. Considerations of geopolitics, economy, tinkering with natural ecology, genocide, and sociology have been advanced in arguments against the broadening of circumstances under which abortion is permissible. *See generally, e. g.*, Callahan, Abortion: Law, Choice and Morality (1970).

shown a compelling public necessity for invading a woman's "right to refuse to carry an embryo during the early months of pregnancy," concluded: "* * * [T]he mother's interests are superior to that of an unquickened embryo whether the embryo is mere protoplasm, as the plaintiff contends, or a human being, as the Wisconsin statute declares." 310 F.Supp. at 301. This conclusion, we believe, is not mandated by the Constitution.

[21, 22] A reading of current and historical writings on the abortion problem convinces us that *Babbitz* and *Roe* were decided upon theories of life and being which a large part of this country does not entertain.[17] "[T]he word 'liberty,' in the 14th Amendment, is perverted when it is held to prevent the natural outcome of a dominant opinion, unless it can be said that a rational and fair man necessarily would admit that the statute proposed would infringe fundamental principles as they have been understood by the traditions of our people and our law." Lochner v. New York, 198 U.S. 45, 76, 25 S.Ct. 539, 547, 49 L.Ed. 937 (1905) (Holmes, J., dissenting). We are not persuaded that the Louisiana abortion laws infringe any fundamental principle as understood by the traditions of our people. As an ethical, moral, or religious matter, a woman's refusal to carry an embryo or fetus to term, both historically and today, has been condemned as wrong by a substantial, if not a dominant, body of opinion, except in very limited circumstances.[18] Common science of our people that it must be

17. The attitudes of a society are reflected, at least to some extent, by the statutes it enacts. In 1965, the abortion legislation of the several States might have been roughly classified as those that, in form, prohibited all abortions and those that permitted abortions under carefully limited circumstances. George, Abortion Laws: Proposals and Movements for Reform, in Abortion and the Law 1 (Smith ed. 1967). A review of state legislation today suggests that attitudes toward abortion are in a state of transition, and discussion of the abortion problem is certainly no longer taboo. *See* Clark, Religion, Morality, and Abortion: A Constitutional Appraisal, 2 Loyola U.L.A.L.Rev. 1 (1969).

18. Views from the ranks of organized religion reflect that abortion has been considered morally wrong, except in very limited circumstances. The circumstances that justify abortion vary from religion to religion and denomination to denomination, and it appears that, on balance, attitudes toward abortion are in a state of transition. The official Roman Catholic position is well known. One Roman Catholic commentator has stated that "* * * Catholic moral theology and philosophy have retained, more than the teaching of most other religious denominations, the traditional, and until recently, unchallenged view that abortion is the taking of the life of an unborn but, nevertheless, a real human being." Drinan, The Inviolability of the Right To Be Born, in Abortion and the Law 107-108 (Smith ed. 1967). The Lutheran Church apparently opposes abortion for any reason, while the Presbyterian Church, at least until recently, has favored abortion only to save the mother's life. Reliance is placed upon the individual conscience by the Unitarian and Episcopal Churches, and the Southern Baptist Church has not taken an official position. Rosen, Abortion in America 154-161 (2d ed. 1967). The Orthodox Jewish position will permit abortion if necessary to save the mother's life, and even a remote risk of life invokes "all the life-saving concessions of Jewish law, provided the fear of such a risk is genuine and confirmed by the most competent medical opinions." Jakobovits, Jewish Views on Abortion, in Abortion and the Law 124, 143 (Smith ed. 1967). For example, the "Jewish concern for the mother is so great that a gravid woman sentenced to death must not be subjected to the ordeal of suspense to await the delivery of her child." *Id.* at 142-143. In contrast, the common law has long known the writ *de ventre inspiciendo* authorizing matrons or "discreet women" to inspect the body of a woman to determine if she is pregnant. This writ was issued, for example, to determine before a hanging whether a convicted female was pregnant. If a child was found to be "alive in the womb," that is, "quick," execution was stayed generally until the child was born or by the course of nature it proved that the woman was not pregnant at all. 4 Blackstone, Commentaries Comm. 1, 395 (4th ed. 1771). Conservative and Reform Jews apparently regard abortion far

convictions and attitudes are subject to change, of course, and the valuation of embryonic and fetal life urged by Dr. Rosen may prove ultimately to be supported by common understanding, but we do not find that his valuation is so supported today.

[23, 24] Section 37:1285(6) of the Louisiana Revised Statutes, we conclude, does not offend the due-process clause of the Fourteenth Amendment. We do not recognize the asserted right of a woman to choose to destroy the embryo or fetus she carries as being so rooted in the traditions and collective conranked as "fundamental." The valuation of embryonic and fetal organisms made by the State of Louisiana is supported by scientific fact. Because we further find that section 37:1285(6) is necessary to the accomplishment of a permissible state policy, we must decline plaintiff's invitation to void this law.[19]

Judgment will be entered in favor of defendant, dismissing plaintiff's suit.

Before AINSWORTH, Circuit Judge, and BOYLE and CASSIBRY, District Judges.

CASSIBRY, District Judge (dissenting):*

"* * * One of the basic values of [the right to] privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was to prevent forma-

more liberally than do Orthodox Jews. Hall, Commentary, in Abortion and the Law 224, 232 (Smith ed. 1967).

The mere assertion, of course, that the action of the State finds justification in the controversial realm of morals "cannot justify alone any and every restriction it imposes. See Alberts v. State of California, 354 U.S. 476, 77 S.Ct. 1304, 1 L.Ed.2d 1498. * * *

"Yet the very inclusion of the category of morality among state concerns indicates that society is not limited in its objects only to the physical well-being of the community, but has traditionally concerned itself with the moral soundness of its people as well. Indeed to attempt a line between public behavior and that which is purely consensual or solitary would be to withdraw from community concern a range of subjects with which every society in civilised times has found it necessary to deal. The laws regarding marriage which provide both when the sexual powers may be used and the legal and societal context in which children are born and brought up, as well as the laws forbidding adultery, fornication and homosexual practices which express the negative of the proposition, confining sexuality to lawful marriage, form a pattern so deeply pressed into the substance of our social life that any Constitutional doctrine in this area must build upon that basis. * * *"

Poe v. Ullman, 367 U.S. 497, 545-546, 81 S.Ct. 1752, 1778, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting); *cf.* Walz v. Tax Commission of City of New York, 397 U.S. 664, 677-678, 90 S.Ct. 1409, 1415-1416, 25 L.Ed.2d 697 (1970).

19. As Mr. Justice Clark has said,

"It is for the legislature to determine the proper balance, *i. e.*, that point between prevention of conception and viability of fetus which would give the State the compelling subordinating interest so that it may regulate or prohibit abortion without violating the individual's constitutionally protected rights."

Clark, Religion, Morality, and Abortion: A Constitutional Appraisal, 2 Loyola U. L.A.L.Rev. 1, 11 (1969). Whether the State of Louisiana, as defendant suggests, has a constitutional duty under the Fourteenth Amendment to protect embryonic or fetal life from destruction by induced abortion is a question we do not consider in the disposition of this case, and we intimate no opinion on its merits.

We have carefully considered Dr. Rosen's contention that section 37:1285(6) denies to him, as well as certain classes of pregnant women, and poor pregnant women generally, equal protection of the laws, which is guaranteed by the Fourteenth Amendment. In particular, we have considered the argument that an affluent woman, whether by legal or illegal means, has a better opportunity than a poor one to obtain an abortion at little risk to her life or health. We are, however, unwilling to equate the types of inequality suggested by Dr. Rosen with a denial of a protected right under the Fourteenth Amendment. Therefore, we reject plaintiff's equal protection argument.

* I concur in those portions of the Court's opinion which hold that we should not abstain and that the abortion laws are not unconstitutionally vague.

tion of the fetus. This, the court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed?" Mr. Justice Clark, Religion, Morality, and Abortion: A Constitutional Appraisal, 2 Loyola Law Review of L. A. 1, 8 (1969)

Because, answer the majority of this Court, a "human life" comes into existence at conception, and the State's interest in protecting that life overrides the fundamental human rights of the mother to the control of her own body and to choose whether to bear a child. But in my view the history and operation of the Louisiana abortion law belie the majority's construction of a purpose to protect human life. If the purpose is to protect life, this law is "the very mirror image"[1] of what one would suppose such a law to be. The law rather seems to be an effort to enforce certain views of private morality against those not sharing those views, see note 25, *supra*. Far from protecting human life it tends in practice to destroy it. And not the least of the evils of this law is that it operates as an invidious discrimination against the poor.

I

Fundamental Nature of the Mother's Rights

In Part I of this opinion I pass over the interests of the fetus, and, for purposes of analysis, focus solely on the impact of the abortion law on the *mother*. In this Part I set up an artificial assumption, that the fetus is no more than a collection of living cells, a part of the mother's own body that, when separated, dies. In the next two Parts of the opinion I consider the exact nature of the State's interest in the fetus.

In a series of cases, culminating in Griswold v. Connecticut, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1964), the Supreme Court of the United States has established an area of fundamental human liberty in matters relating to marriage, the family and children. This development is summarized by Mr. Justice White in his concurring opinion in *Griswold* (at 502, 85 S.Ct. at 1691): "It would be unduly repetitious, and belaboring the obvious, to expand on the impact of this [Connecticut anticontraceptive law] on the liberty guaranteed by the Fourteenth Amendment against arbitrary and capricious denials or on the nature of this liberty. Suffice it to say that this is not the first time this Court has had occasion to articulate that the liberty entitled to protection under the Fourteenth Amendment includes the right 'to marry, establish a home and bring up children,' Meyer v. State of Nebraska, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 and 'the liberty * * * to direct the upbringing and education of children,' Pierce v. Society of Sisters, 268 U.S. 510, 534–535, 45 S. Ct. 571, 573, 69 L.Ed. 1070, and that these are among 'the basic civil liberties of man.' Skinner v. State of Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 [compulsory sterilization of habitual criminals]. These decisions affirm *that there is a 'realm of family life which the State cannot enter without substantial justification.* Prince v. Com. of Massachusetts [321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645]' * * *." (emphasis added).

Griswold reaffirmed and extended these principles. In the most sweeping terms the Court struck down a criminal law which infringed on the rights of Connecticut couples to practice contraception. Although Mr. Justice Douglas's opinion for the Court focused upon the right of "marital privacy," there is no question that the right to prevent unwanted birth of children was involved as well.[2] Mr. Justice Goldberg (joined

1. Baird v. Eisenadtadt (1 Cir. 1970), 429 F.2d 1398.

2. The United States Court of Appeals for the First Circuit has interpreted *Griswold* as establishing a fundamental right of birth control. *Baird*, note 1, *supra*. In

by Mr. Chief Justice Warren and Mr. Justice Brennan) spoke of "The marital *right to bear children and raise a family*," 381 U.S. at 497, 85 S.Ct. at 1688 and found that the Constitution protected "against * * * *totalitarian limitation of family size*, which is at complete variance with our constitutional concepts." *Id.* (emphasis added); and Mr. Justice White stressed the fact that "The Connecticut anti-contraceptive statute * * * forbids all married persons to use birth control devices *regardless of whether their use is dictated by considerations of family planning, health, or even life itself* * * * [and that the] clear effect of these statutes, as enforced, is to deny disadvantaged citizens * * access to medical assistance and up-to-date information in respect to proper methods of *birth control*." 381 U.S. at 503, 85 S.Ct. at 1691, 1692 (emphasis added)

It is true that the *Griswold* Court did not pass upon the precise question presented here: *Griswold* involved contraception; this case involves abortion. Nevertheless *Griswold* is critically relevant to the present case. For unlike a procedural holding which may be narrowly confined to its particular facts, the *Griswold* decision rested upon the broadest and most sweeping principles of substantive constitutional law. The various opinions may have disagreed as to the methodology by which, or the particular Amendments from which, the right of family privacy is derived. But on one point the seven majority Justices agreed: The "right," be it derived from the First or Fourth, the Ninth or Fourteenth, Amendments, or all of them, was a right "so rooted in the traditions and conscience of our people as to be ranked as fundamental." 381 U.S. at 487, 85 S.Ct. at 1683.

The language of the *Griswold* opinions is strong and unequivocal. Mr. Justice Harlan found that "For reasons stated at length in my dissenting opinion in Poe v. Ullman * * * [the Connecticut] enactment violates basic values 'implicit in the concept of ordered liberty,' Palko v. Connecticut [citation omitted]." 381 U.S. at 500, 85 S.Ct. at 1690. In Mr. Justice White's view "[the] decisions affirm that there is 'a realm of family life which the State cannot enter' without substantial justification [citation omitted]." And Mr. Justice Goldberg, Mr. Chief Justice Warren, and Mr. Justice Brennan considered that "the integrity of that [family] life is fundamental," Griswold v. Connecticut, *supra*, 381 U.S. at 495, 85 S.Ct. at 1687, that it is one of "the requirements of a free society," *Id.* at 493, 85 S.Ct. at 1687 (quoting from Poe v. Ullman, dissenting opinion of Mr. Justice Douglas), and that it "is of such a character that it cannot be denied without violating those 'fundamental principles of liberty and justice which lie at the base of all our civil and political institutions' * * *." *Id.* at 493, 85 S.Ct. at 1686.

For me, then, the *Griswold* case contains a broad command. It says, to this and other courts: You must protect the

a case involving the application of the Massachusetts anti-contraceptive law to single persons the Court said:

"[W]e consider that [the law] conflicts with fundamental human rights. In the absence of demonstrated harm, we hold that it is beyond the competency of the state. See the various opinions in Griswold v. Connecticut, *supra*, particularly those of Mr. Justice Harlan and Mr. Justice White, concurring. See also Richards v. Thurston, 1 Cir., 4/28/70, 424 F.2d 1281." (Aldrich, C. J.).

Several other courts have held that *Griswold's* right of privacy extends to single persons, and, in the "absence of demonstrated harm," to abortion as well as contraception: People v. Belous, 71 Cal.2d 996, 80 Cal.Rptr. 354, 458 P.2d 194 (1969); Babbitz v. McCann, 310 F.Supp. 293 (E.D.Wis., 1970); see particularly State v. Munson (Cir.Ct., Pennington County, S. Dakota, April 6, 1970); Roe v. Wade, 314 F.Supp. 1217 (N.D.Texas, Civ. Nos. 3-3690-B & 3-3691-C, June 17, 1970). See also United States v. Vuitch, 305 F.Supp. 1032 (D.D.C., 1969).

I agree with these courts that *Griswold* establishes a right of birth control, and I see no reason to limit the right to married persons (see note 25, *supra*).

privacy and intimacy of family life, for such relationships lie at the very core of a free society. And laying aside for the moment the interest of the State, I have no doubt that the Louisiana abortion statute falls within this sensitive area.

Indeed in some ways the right to have an abortion is even more compelling than the rights involved in *Griswold*. Contraception involves the first line of defense against an unwanted birth; abortion the last. At the point contraceptives are used birth is only a possibility; there are a number of forces tending to prevent it apart from contraception. When a mother seeks an abortion, however, she has already conceived. Unless a spontaneous abortion or miscarriage occurs, she is faced with the *immediate* reality of carrying and bearing a child against her will. At least two fundamental human rights are thus involved: The mother's autonomy over her own body, and her right to choose whether to bring a child into the world.[3]

It is difficult to overstate the importance of what the mother has at stake. In physical terms alone the thought of making a mother carry and bear a child against her will is not a pleasant one.[4] But the matter cuts much deeper than mere physical pain. Carrying and bearing a child may involve anxiety and trauma and great psychic pain. See Aarons (M.D.), "Therapeutic Abortion and The Psychiatrist," American J. Psychiat. 124:6, December 1967. Infrequently it results in suicide. *Id.* In some cases the child may be born deformed, or the birth may in this or other respects impair the physical and mental health of the mother. Poor families, with little ability to take advantage of means of self-protection that are of easy access to the rich, see, e. g., Griswold v. Connecticut, 381 U.S. 479, 503, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1964) (concurring opinion of Mr. Justice White), often suffer physical, and therefore possibly other kinds of deprivation by the constant birth of children. But perhaps most important, the birth of a child unalterably affects the emotional lives of both mother and child. At its best, it makes possible a relationship of love; at its worst, it creates an unwanted child. When the State seeks to touch the very core of a person's being in such a fashion, and to thrust upon mother and (potential) child such a relationship *by force*, it violates "those 'fundamental principles of liberty and justice which lie at the base of all our civil and political in-

3. The majority argue that the right to abortion cannot be equated with the general right to choose whether or not to bear a child since alternative means are available to prevent conception. This argument is unrealistic. More than a million women found it necessary to have abortions last year (Life Magazine, Feb. 27, 1970). Kinsey found that 22% of the married women interviewed had had one or more abortions by age 45. Abortion in the United States, 50, 54 (Calderon ed. 1958). Between 88 and 95% of the premarital pregnancies in his sample resulted in abortion. Obviously there are great numbers of women who, for one reason or another, are not able to utilise alternative methods. See Griswold v. Connecticut, 381 U.S. 479, 503, 85 S.Ct. 1678, 1692, 14 L.Ed.2d 510 (1964) (concurring opinion of Mr. Justice White).

4. The authority for the idea that the Constitution extends significant protection to a person's sovereignty over his own body extends back as early as 1891, when the Supreme Court stated:

"No right is held more sacred, [n] or is more carefully guarded * * * than the right of every individual to the possession and control of his own person, free from all restraints or interference of others unless by clear and unquestionable authority of law. As well said by Judge Cooley, 'The right to one's person may be said to be a right of complete immunity: to be let alone.'" Union Pacific Railroad v. Botsford, 141 U.S. 250, 251, 11 S.Ct. 1000, 35 L.Ed. 734 (1891).

Of course the right has limits. In Jacobson v. Massachusetts, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1904), for example, the Supreme Court upheld a compulsory vaccination law. The lengths to which the Court went, however, to justify a shot in the arm point up the degree to which personal autonomy is entitled to protection.

stitutions * * *.' [citation omitted]." *Griswold, supra*, 381 U.S. at 493, 85 S.Ct. at 1687 (concurring opinion of Mr. Justice Goldberg). As Mr. Justice Brandeis said, dissenting in Olmstead v. United States, 277 U.S. 438, 478, 48 S.Ct. 564, 572, 72 L.Ed. 944 (1928):

> "The protection guaranteed by the [Fourth and Fifth] amendments is much broader in scope. The makers of our Constitution undertook to secure conditions favorable to pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure and satisfactions of life are to be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone—the most comprehensive of rights and the right most valued by civilized men." [5]

That the State in these circumstances bears a heavy burden of proof to justify the law is beyond doubt.[6] Louisiana urges upon us the protection of human life, a claim which bears examining. Meanwhile, however, both parties have confused the matter by their use of the science of biology.

II

The Relevance of Biology

The biological evidence presented in this case suggests that some sort of human organism exists from the time of conception.[7] The parties, however, would go further and make biology conclusive, for both court and legislature, as to the existence or non-existence of a "human being" at the time of conception. These efforts seem misplaced.

The meaning of the term "human being" is a relative one which depends on the purpose for which the term is being defined. To the scientist a "human being" may be no more than union of sperm and egg; to the poet or to society as a whole the term may connote something else.[8] Science at best marks the

5. This passage is quoted in Mr. Justice Goldberg's concurring opinion in *Griswold, supra* at 550, 85 S.Ct. 1678 and by Mr. Justice Harlan in his dissent in Poe v. Ullman, 367 U.S. 497, 550, 81 S.Ct. 1752, 6 L.Ed.2d 989 (1961).

6. See Part III of this opinion.

7. Compare the following excerpt from the cross-examination of Dr. Christopher Tietze, an expert witness in the field of medicine (TR. 14, 2):

> "Q. Dr. Tietze, I do not mean to keep quarreling with you, but you keep referring to a human person and under your definition of a human person, you may well be right. I have asked you in my question with regard to a human being, is the embryo a human being in an earlier state of development of the fetus?"
>
> "A. If you will define, if you are referring, apparently to a human being as something begotten by man and potentially to become man, yes, it would be an early stage of a human being. But this is a very special definition and I think an essential one to the discourse between you and me."
>
> * * * * *
>
> "Q. It is also fair to say that this zygote is an organism of the same gene structure of a fully-grown, highly complex adult?"
>
> "A. It has the same, yes * * *."

8. Cross-examination of Dr. Christopher Tietze, TR. 4–5:

> "Q. Now, with regard to this zygote which is an early embryo, which is an early fetus, in biological terms, would it be not a fair statement to say that this is a human being?"
>
> "A. I think we are getting ourselves, now, into a philosophical question. I would say as a close approximation to my own reaction to this thing—and that is what we all must do, is face philosophical conceptions—that it is a potential human being and I would not refer to the zygote as an early embryo, I would refer to the zygote as a potential embryo."
>
> * * * * *
>
> "Q. You injected the word philosophical, philosophy, and I ask you from a biological standpoint, isn't this zygote, this embryo, this fetus a human being?"
>
> "A. I think the term human being, with all of its connotations, extends far beyond biology and is a philosophical con-

outermost limits of life; it cannot tell us nearly so well what a human being *is* as it can what a human being definitely *is not*. The Romans, for example, practiced infanticide with indifference.[9] No doubt the science of the Romans regarded the infant as a human being; but can one say the Romans did?

Present practice as well shows the futility of attempting to frame the question in terms of absolutes.[10] In Louisiana, for example, a mother who intentionally destroys her own fetus is guilty of no criminal offense, see, e. g., Simmons v. Victory Indus. Life Ins. Co., 18 La.App. 660, 139 So. 68 (Orleans Ct.App.1932); however, the moment the infant is born, the same act is punishable by the penalty "which the law exacts in all such cases, which penalty is death." State of Louisiana v. Burks, 202 La. 167, 11 So.2d 518, 520 (Sup.Ct.La.1942); La.Rev.Stat. Ann. 14:30 (1950).

The question in this case, then, is not the abstract one of whether a fetus is a "human being," but the more concrete one of the extent to which human value has been assigned to the fetus by *Louisiana*.

We must analyze the precise nature of the State's interest in the fetus to determine whether, a part from the "label" it carries, it is in *substance* the kind of interest which is "compelling" and which "subordinates" the rights of the mother. Griswold v. Connecticut, 381 U.S. 479, 496, 504, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965).[11]

cept. If you ask me whether the zygote normally in the course of circumstances, with exceptions, will develop into a human being, obviously the answer is yes. Whether this human being meets all of the other qualifications that we attach to this important term, I submit, is not a question of biology * * *."

* * * * *

"A. * * * To be a human person in any society is something conferred to an individual by his fellow citizens. In some societies, a child was not a human person, in the sense that his parents could do away with him at will * * * I think what we call a human person is an imputed quality, a quality conferred by the society * * *."

Compare the following statement of Mr. Justice Clark:

"To say that life is present at conception is to give recognition to the potential, rather than the actual. The unfertilized egg has life, and if fertilized, it takes on human proportions. But the law deals in reality, not obscurity—the known rather than the unknown. When sperm meets egg life may eventually form, but quite often it does not. The law does not deal in speculation. The phenomenon of life takes time to develop, and until it is actually present, it cannot be destroyed. Its interruption prior to formation would hardly be homicide, and as we have seen, society does not regard it as such. The rites of Baptism are not performed and death certificates are not required when a miscarriage occurs. No prosecutor has ever returned a murder indictment charging the taking of the life of the fetus. This would not be the case if the fetus constituted human life." Loyola of L.A.Rev., vol. 2 (1969).

9. Comment, To Be Or Not To Be: The Constitutional Question of the California Abortion Law, 118 U.Pa.L.Rev. 643, 653, n. 60 (1970) (citing J. Noonan, Contraception, 85–87 (1965).

10. "* * * In the ultimate analysis Catholics do not differ from advocates of easy abortion because Catholics hold that a human life is present in the fetus from the earliest moment of its existence. Catholics differ with their opponents rather over the nature and quality of the reasons which can justify an abortion. Utilizing the traditional principles of moral theology Catholic thought justifies at least the termination of an ecoptic pregnancy and the unintended destruction of a fetus when the removal of a uterus is medically required. Catholics therefore should move away from any line of reasoning or species of rhetoric which suggests that the proponents of abortion are advocating homicide. Catholics should delimit the question to the more precise issue involved, namely, the nature of the reasons which can furnish a moral justification for the termination of the existence of the fetus."
Robert F. Drinan, The Morality of Abortion Laws, Association for the Study of Abortion, Inc., Reprint 1 (1968). (Father Drinan was the Dean of the Boston College Law School, and has just been elected to Congress).

11. Concurring opinions of Mr. Justice Goldberg and Mr. Justice White.

III

The Louisiana Abortion Statute

The opinion of the majority reads very much as though this were a case involving the validity of an ordinary police measure. Every doubt is resolved in favor of the law. Normally, of course, this is as it should be when the serious question of the constitutionality of legislation is raised. But "Surely the right involved in this case * * * 'come[s] to this Court with a momentum for respect lacking when appeal is made to liberties which derive from shifting economic arrangements.' Kovacs v. Cooper * * * (opinion of Frankfurter, J.)." Griswold v. Connecticut, 381 U.S. 479, 502, 85 S.Ct. 1678, 1691, 14 L.Ed.2d 510 (1965) (concurring opinion of Mr. Justice White).

"Where there is a significant encroachment upon personal liberty," the presumption of constitutionality is reversed, and "the *State* may prevail only upon *showing* a subordinating interest which is compelling." *Griswold, supra*, at 504, 85 S.Ct. at 1692 (concurring opinion of Mr. Justice White) (emphasis added). I take it then that the State has the burden of proof, see, e. g., Shapiro v. Thompson, 394 U.S. 618, 634–638, 89 S.Ct. 1322, 22 L.Ed.2d 600 (1969);[12] Sherbert v. Verner, 374 U.S. 398, 406–407, 83 S.Ct. 1790, 10 L.Ed.2d 965 (1963);[13] Bates v. City of Little Rock, 361 U.S. 516, 525–527, 80 S.Ct. 412, 4 L.Ed.2d 480 (1960);[14] Skinner v. State of Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942),[15] or that, at the very least, the fundamental rights at stake here

> "require particularly careful scrutiny of the State needs asserted to justify their abridgment." Mr. Justice Harlan, dissenting in Poe v. Ullman, 367 U.S. 497, 543, 81 S.Ct. 1752, 1777, 6 L.Ed.2d 989 (1961)

I turn to the statute [La.Rev.Stat.Ann. § 14:87 (Supp.1970)]:

> "87. ABORTION
>
> Abortion is the performance of any of the following acts, with the intent of procuring premature delivery of the embryo or fetus:
>
> (1) Administration of any drug, potion, or any other substance to a female; or
>
> (2) Use of any instrument or any other means whatsoever on a female.
>
> Whoever commits the crime of abortion shall be imprisoned at hard labor for not less than one nor more than ten years." As amended, Acts 1964, No. 167.

12. At pp. 634–637, 89 S.Ct. at pp. 1331–1333 the Court analyzes the State's asserted justifications for the residency requirement for welfare and finds that they are "plainly belied" by the facts (p. 635, 89 S.Ct. p. 1332) and will not "withstand strict scrutiny." (p. 636, 89 S.Ct. p. 1332)

13. "It is basic that no showing merely of a rational relationship to some colorable State interest would suffice; in this highly sensitive constitutional area, 'only the gravest abuses, endangering paramount interests, give occasion for permissible limitation' * * *." (p. 406, 83 S.Ct. p. 1795).
At p. 407, 83 S.Ct. at p. 1795 the Court referred to the "asserted state interest" and concluded that "*Nor * * * would the record appear to sustain it.*" (emphasis added)

14. "It cannot be questioned that the governmental purpose upon which the municipalities rely is a fundamental one. No power is more basic to the ultimate purpose and function of a government than is the power to tax. * * * But governmental action does not automatically become reasonably related to the achievement of a legitimate and substantial governmental purpose by mere assertion in the preamble of the ordinance. When it is shown that state action threatens significantly to impinge upon constitutionally protected freedom it becomes the duty of this Court to determine whether the action bears a reasonable relationship to the achievement of the governmental purpose asserted as its justification." (p. 524, 80 S.Ct. p. 417)

15. "Strict scrutiny [of state sterilization law] is essential * * *."

Defendants urge again and again in their brief, and the majority of this court accept, the proposition that we are here dealing with a statute whose purpose is the protection of "human life." If this is true it is certainly not apparent from the statute itself. Unlike, for example, the Wisconsin statute,[16] which specifically refers to the "life" of an unborn "child," and defines "unborn child" as "a human being from the time of conception until it is born alive," the Louisiana statute makes no reference to "human life;" it refers only to the "embryo or fetus."[17] In Wisconsin the crime of abortion consists of "intentionally *destroy[ing]* the life of an unborn child." (emphasis added) In Louisiana, on the other hand, the crime consists of performing various acts on a "female" for the "*purpose* of procuring *premature delivery*." (emphasis added). Thus in Wisconsin no crime is committed unless the life of the fetus is actually terminated. In Louisiana, "[The abortion statute] does not use the word 'attempt,' but penalizes the felonious administration of any drug, potion, or anything to any woman, for the purpose of procuring abortion or premature delivery, and prescribes *only one penalty*.. Hence Section 807 makes no distinction between the attempt and the actual procurement of abortion or premature delivery." State of Louisiana v. Mauvezin, 136 La. 746, 67 So. 816 (1915) (emphasis added). So far as I have been able to determine, abortion is the only crime in Louisiana in which there is no distinction between an attempt and commission of the substantive crime.[18] (Indeed the "attempt" in Louisiana *is* the substantive crime). In past versions of the statute the subject of an abortion was a "pregnant"[19] female; in 1964 the legislature decided that any "female" would do. Finally, it is not even certain whether an intent to terminate fetal life is necessary for a conviction under the Louisiana statute. The 1870 statute, as

16. Wis.Stat. § 940.04:
"(1) Any person, other than the mother, who intentionally *destroys* the *life* of an unborn *child* may be fined not more than $5,000 or imprisoned not more than 3 years or both.
(2) Any person, other than the mother, who does either of the following may be imprisoned not more than 15 years:
(a) intentionally destroys the *life* of an unborn quick child; or * * *
(6) In this section 'unborn child' means a *human being* from the time of conception until it is born alive." (emphasis added)

17. Compare La.Rev.Stat.Ann. § 14:29, entitled "Homicide," which provides in part:
"Homicide is the killing of a *human being* * * *." (emphasis added)
and La.Rev.Stat.Ann. § 14:30, entitled "Murder," which reads in part:
"Murder is the killing of a *human being* * * * [with specific intent to kill] * * * whoever commits the crime of murder shall be punished by death."

18. Compare La.Rev.Stat.Ann. § 14:27, entitled "Attempt," which provides in part:
"Any person who, having a specific intent to commit a crime, does or omits an act for the purpose of or tending directly toward the accomplishing of his object is guilty of an attempt to commit the offense intended; * * *
Whoever attempts to commit any crime shall be punished as follows:
(1) If the offense so attempted is punishable by death or life imprisonment he shall be imprisoned at hard labor for not more than twenty years;
(2) If the offense so attempted is theft or receiving stolen things, he shall be fined not more than two hundred dollars, or imprisoned for not more than one year, or both;
(3) In all other cases he shall be fined or imprisoned, or both, in the same manner as for the offense attempted; but such fine or imprisonment shall not exceed one-half of the largest fine, or one-half of the longest term or imprisonment prescribed for the offense so attempted, or both."

19. The 1942 version of the statute, La.Rev.Stat.Ann. § 14:87, read in pertinent part:
"* * * (1) Administration of any drug [etc.] * * * to a *pregnant* female; or
(2) Use of any instrument [etc] * * * on a *pregnant* female, * * *" (emphasis added)

amended, La.Acts, 1888, No. 24,[20] prohibited certain acts with intent to procure an "abortion" *or "premature delivery"*. (emphasis added). Today the statute does not even use the word "abortion" but simply the broader term "premature delivery."

Thus the Wisconsin statute at least purports to emphasize the life of the fetus; the Louisiana statute focuses more on an intent to interfere with nature irrespective of the fate of the fetus (or indeed of whether there even is a fetus). Along with "prostitution," "crimes against nature," etc. the crime of abortion in Louisiana is an "Offense Affecting Sexual Immorality"[21] rather than an "Offense Against The Person."[22] The provision of the Criminal Code immediately following Abortion, entitled "Distribution of Abortifacients,"[23] provides *one penalty* for distribution of abortifacients *or contraceptives*[24] (Cf. Baird v. Eisenstadt, 1 Cir., 1970, 429 F.2d 1398: "We are led inevitably to the conclusion that * * * it is contraceptives *per se* that are considered immoral * * *.")[25]

20. "Whoever shall feloniously administer, or cause to be administered, any drug, potion, or any other thing, to any woman for the purpose of procuring a *premature delivery*, or whoever shall administer, or cause to be administered, to any woman pregnant with child, any drug, potion, or any other thing, for the purpose of procuring *abortion* or a premature delivery, or whoever by any means whatsoever shall feloniously procure abortion or premature delivery, shall be imprisoned at hard labor for not less than one nor more than ten years." (emphasis added)

21. La.Rev.Stat.Ann. § 14:80–89.

22. La.Rev.Stat.Ann. § 14:29–50.

23. La.Rev.Stat.Ann. § 14:88.

24. "We call your attention to Act 95 of 1920, [the predecessor of the present Abortifacient Statute, note 19 *supra*] which is an Act to prohibit the printing or publishing of an advertisement of any secret drug for the use of females for the procurement of abortion or prevention of conception * * * We are therefore of the opinion that birth control in any form would fall within the criminal statutes now in force in this state."
Op.Atty.Gen. of La. 128, 129 (1932–1934). See also Ops.Atty.Gen. of La. 73 (1934–1936); Comment, 23 La.L.Rev. 773, 775 (1963).
The framers of the 1942 Criminal Code were aware of this interpretation of the law at the time they re-enacted it, see Morrow, The Louisiana Criminal Code of 1942—Opportunities Lost and Challenges Yet Unanswered, 17 Tul.L.Rev. 1, 22 (1942) (Morrow was one of the principal reporters of the Code).

25. H. L. A. Hart has distinguished between "public" and "private" morality in the criminal law. "Public" morality involves actions that are harmful independent of their repercussion on the general moral code. Rape is an example. "Private" morality involves actions that are not harmful to others but offensive to prevailing (or sometimes not so prevailing) moral feelings. Examples are fornication or consenting homosexuality. As Hart puts it, a particular practice violates private morality "if the thought of it makes the man on the Clapham omnibus sick." 62 Listener 162, 163 (July 30, 1959).

In John Stuart Mill's view government has no business enacting *private* morality into the criminal law:

"The only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others. His own good, either physical or moral, is not sufficient warrant."

On Liberty.

The British government has adopted Mill's position. See Report of the Committee on Homosexual Offenses and Prostitution (Wolfenden Report) 9–10, 20–21, 24, 79–80 (1957). So has the American Model Penal Code, see Tentative Draft No. 4, Comments to Article 207, Sexual Offenses. In the United States, however, courts often affirm—almost always in dictum—the propriety of statutes against fornication, etc. See e. g., Griswold v. Connecticut, 381 U.S. 479, 498–499, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) (concurring opinion of Mr. Justice Goldberg). But where fundamental rights are involved, as they are in this case, private morality alone cannot justify their abridgment:

"The mere assertion that the action of the State finds justification in the controversial realm of morals cannot justify alone any and every restriction it im-

Concern for the protection of human life, then, is hardly manifest from the face of the statute.[26] In actual operation the statute fares even worse. Since 1870, when the abortion law was first enacted, there have been no more than four reported decisions of prosecutions.[27] There are only two reported prosecutions subsequent to 1955. All of these prosecutions are against the "criminal" abortionist; as against the *physician* there are no reported decisions of prosecutions.[28]

Perhaps even more revealing, however, is the fact that the *woman* who submits to abortion is guilty of no criminal offense:

> "It is true that a female who voluntarily becomes the subject of an abortion, without justifiable medical reason, is guilty of a detestible and revolting offense against the laws of nature, which is universally condemned, but notwithstanding this, such woman is not guilty of any criminal offense known to the laws of this state." Payne v. Louisiana Ind. Life Ins. Co., 33 So.2d 444 (Orleans Ct. App.1948)

This is true even in the case where the woman intentionally aborts herself. Simmons v. Victory Indus. Life Ins. Co., *supra*. It may be argued that the reason for exempting the mother is to encourage her to testify against the "abortionist." But surely this puts the cart before the horse. Suppose, for example, that A hires B to kill C; would the State

poses." Poe v. Ullman, 367 U.S. 497, 545, 81 S.Ct. 1752, 1778, 6 L.Ed.2d 989 (1961) (dissenting opinion of Mr. Justice Harlan). See also Baird v. Eisenstadt, *supra*.

26. Both parties seek to show the State's interest or lack of it in the fetus by pointing to various succession laws. One statute, for example, says that children in the womb are considered as already born and that an inheritance may "devolve" to them before their birth. La.Civ.Code Ann. Art. 29. See also La.Civ.Code Ann. Art. 954. But the right to inherit does not vest unless or until the child is "born alive," La.Civ.Code Ann. Arts. 956-957, and "children born dead are considered as if they had never been born or conceived." La.Civ.Code Ann. Art. 28.

In my view the succession laws are of doubtful relevancy to the abortion statute; at any rate they are too contradictory to support the argument of either party.

27. State of Louisiana v. Sharp, 248 La. 865, 182 So.2d 517 (1966); State of Louisiana v. Pailet, 246 La. 483, 165 So. 2d 294 (1964); State of Louisiana v. Dore, 227 La. 282, 79 So.2d 309 (1955); State of Louisiana v. Mauvesin, 136 La. 746, 67 So. 816 (1915).

Compare the "Gambling" statute, La. Rev.Stat.Ann. § 14:90, under which there have been at least 50 reported prosecutions. "Sodomy" (Abortion's bedmate in the Code) has even resulted in a greater number of reported prosecutions.

28. The absence of reported cases is not the only evidence of failure to prosecute the physician:

> "The lack of enforcement was noted in 1868, H. Storer & F. Heard, Criminal Abortion 136-147 (1868), and has continued to the present, *see* L. Lader, Abortion 70-73 (1966); Ziff, Recent Abortion Law Reforms (Or Much Ado About Nothing) 60 J.Crim.L.C. & P.S. 3, 8 (1969)." 118 U.Pa.L.Rev. 647, 657, n. 87 (1969).

Speaking of the considerations that Dr. Belous might have weighed in deciding whether or not to perform an abortion in California one writer could blithely conclude "Considering the fact that the possibility of criminal prosecution and loss of practice is rarely realized. * * *" *Id.*

And here in Louisiana Professor C. J. Morrow, to whom defendants refer in their brief as "one of the principal redactors of the Criminal Code," has observed as a fact what the lack of reported prosecutions reflect:

> *"It is common knowledge that abortions of all types are performed every day, and that there are no criminal prosecutions. This is true because there is obviously common popular acceptance of the practice, in spite of the theoretical disapproval in some quarters. However the tremendously unfortunate aspect of the situation is that under the present state of the law doctors are forced into either open defiance of the positive law in what they deem to be justifiable cases, or into clandestine practice under substandard conditions."* Morrow, The Louisiana Criminal Code of 1942—Opportunities Lost and Challenges Yet Unanswered, 17 Tul.L.Rev. 1, 22 (1942) (emphasis added).

grant A immunity in exchange for his testimony against B? If abortion is truly regarded as the destruction of human life, the mother is the principal criminal; the "abortionist" is merely her paid executioner. If the State really means to protect the life of the fetus why does it fail to deter the person most directly responsible for taking it? Save for the instigation of the mother the "criminal abortionist" would not exist. Finally, why is the woman who aborts herself immune? Perhaps it will be argued that otherwise she may be afraid to seek medical help if injury results; but this proves only that the health of the mother is considered more important than the preservation of the fetus.[29]

See *conclusion "2", infra.*

The conclusions I draw from the foregoing facts are as follows:

(1) In practice the efforts of the State on behalf of the fetus belie the claim of a compelling state interest. Abortion actually occurs on a massive scale in the United States—estimates run between one and three million per year. Yet there is no significant attempt at deterrence. "Lamented" by some, "decried" by others, the fact remains that the phenomenon of abortion is ignored by most. The fetus in Louisiana is shielded neither from mother nor physician by the criminal law; rather the mother is shielded (rather imperfectly) from the quack. Abortion is thus a singular "crime" in our law; it is a crime without a criminal. A poor person who may steal for the most pressing human needs is branded as a "thief" and punished by the criminal law—often severely. This comes as no surprise: Our society holds the institution of private property in high regard; he who tampers with it does so at his peril. A mother, however, may take the life of her fetus at pleasure so far as the criminal law is concerned. In practice, so may a licensed physician. Surely the remarks of Mr. Justice Frankfurter in the Connecticut Birth Control case are relevant here:

"* * * The undeviating policy of nullification by Connecticut of its anti-contraceptive laws throughout all the long years that they have been on the statute books bespeaks more than prosecutorial paralysis. * * * Deeply embedded traditional ways of carrying out state policy * * *—or not carrying it out—are often tougher and truer law than the dead words of the written text." Poe v. Ullman, 367 U.S. 497, 502, 81 S.Ct. 1752, 1755, 6 L.Ed.2d 989 (1961)

(2) The statute is irrational and self-contradictory, a menace to public health without serving any compensating public need. As previously noted prosecution seems to be almost exclusively against the quack and not the physician. Since the crime, *qua fetus*, is equally great when committed by a physician *the enforcement* of the statute manifests little or no concern for the fetus but rather an overriding concern for the protection of the safety and health of the mother. Yet the menace to public health is clearly the product of the statute itself. The statute's primary effect is not to prevent or deter abortion, see "Conclusion (1)," *supra*, but simply to make it unsafe. Can it be said that there is a "reasonable relation between the prohibition * * * and the protection of the public health, education and welfare"? Sperry & Hutchinson Co. v. Director, 307 Mass. 408, 418, 30 N.E.2d 269, 275 (1940), or that the statute "bears a reasonable relation to a proper legislative purpose * * *." Nebbia v. New York, 291 U.S. 502, 537, 54 S.Ct. 505, 516, 78 L.Ed 940 (1934); Meyer v. Nebraska, 262 U.S. 390, 399–400, 43 S.Ct. 625, 67 L.Ed. 1042 (1923)?

29. Compare the child battering cases. One of the reasons heavy penalties sometimes are not imposed is to encourage the child batterer to seek medical help for the child. Thus low penalties are no indication that the crime is taken lightly but rather that the need to protect the welfare of the child is balanced against the need to punish the child batterer. In the situation where the mother aborts herself, however, if any balance is struck it is struck in favor of the mother, not the child.

(3) The statute inflicts cruel and unusual punishment on the mother and violates equal protection of the law. As pointed out, the State does not attempt to deter abortion by imposition of criminal sanctions directly on the principal actor—the mother. At the same time, however, it makes it illegal for anyone else to perform an abortion. This of course has the effect of raising the price of abortion at all levels of skill. Thus to the extent that the statute deters the mother, it does so only by putting safe abortion beyond her means or by making her risk serious bodily injury at the hands of a relatively low-priced unskilled abortionist.

In Baird v. Eisenstadt, *supra*., the Court of Appeals for the First Circuit held that it was impermissible for Massachusetts, through its anti-contraceptive law, to pursue a policy of deterring fornication "by making the penalty a personally, and socially, undesired pregnancy." The present case is probably distinguishable from *Baird*. I do not think the legislature *intended*[30] to encourage women to risk their health and lives; but because the statute makes abortion illegal for everyone but the mother it works precisely that result.

This purposeless suffering which the statute brings about is made all the more intolerable by the fact that its victims are primarily the poor:

> "The present law places an unfair discrimination on the poor in that persons with money may obtain safe abortions either by travelling to other jurisdictions, by going to high priced competent though illegal abortionists, or by obtaining legal abortions here based on 'sophisticated indications.'" Report of the Governor's Commission Appointed to Review New York State's Abortion Laws, 17 (Mar.1968)

Deaths and maiming from abortion by nonmedical means such as soaps, chemicals, knitting needles, coathangers, etc., appear to be the basic if not the exclusive property of the non-white poor. Gold,[31] for example, shows that between 1960–62 in New York City abortion accounted for 55.5%, 49.4% and 25.2% respectively of the Puerto Rican, nonwhite and white puerperal death rates. Gold does not report figures for injury short of death, but one can imagine the toll they must take in the ghetto.

30. But see defendant's brief: "Plaintiff also argues that the statute prohibiting abortions forces women to take 'coat hangers and knitting needles' * * * and that this could be corrected by repealing or holding the statute unconstitutional. It is argued that forcing women to go to unskilled abortionists is more of a danger to their health. This is a specious argument. *It is neither necessary nor proper for society to remove obstacles that are in the way of the criminal in order to make it easier to commit the crime.*" (emphasis added)

31. Gold, Erhardt, Jacobziner & Nelson, Therapeutic Abortions in New York City: A Twenty Year Review, 55 Am.J.Pub. Health 964 (1965); see also Note, Abortion and the Law: A Proposal for Reform in Louisiana, 43 Tul.L.Rev. 834, 836–837 (1969):

> "Because the demand for abortion cannot be met within the existing legal framework, illegal means are increasingly employed. For an affluent woman, able to pay a fee of $300 to $600, skilled physicians willing to work outside the law are available. [Citing Time, vol. 90, Oct. 13, 1967 at 33] Indeed in Miami alone abortionists collected $20,000,000 for their services in 1967 * * * [citing Time, *supra*].
>
> Since hospital abortions are generally unavailable to precisely those persons who are unable to afford the expensive and illegal private abortions the less affluent are forced to resort to the unskilled. [citing L. Lader, *Abortion* (1967)] Obviously the greater proportion of the more than 1,000 deaths annually due to abortions [citing Time, *supra*] occur among these expectant mothers. However, the annual death toll is only a small part of the social cost of such a system. To the death toll must be added thousands of women crippled by infection, thousands whose sexual organs are damaged so that they are unable to achieve normal sexual satisfaction, and thousands rendered irreversibly barren [citing Time, *supra*]. These, then, are the results of the prevailing American solution to the problems posed by abortion."

If the penalty is built-into the statute, so is the discrimination. *Cf.* Griswold v. Connecticut, 381 U.S. 479, 503, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965);[32] Skinner v. Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942).[33] See also note 31, *supra*. By making abortion legal for the mother, but illegal for anyone else, the statute's *sole* effect on the mother is to raise the price of abortion. Abortion becomes less available to the degree to which one is not able to afford the "tax." For some the higher price is not an obstacle; for others it is either prohibitive, or, to the extent to which forces them to go to the less skilled practitioners (or to abort themselves), highly dangerous. If criminal sanctions were applied to well-off and poor women alike (not just in theory but in practice), as well as to the "abortionist," the increased price of abortion would be an *additional* (as well as unavoidable) deterrent, *but not the only one*. But the Louisiana statute does not deter rich and poor alike by equal application of the criminal law; it simply makes safe abortion less available to the poor than it would otherwise be. The person with means remains perfectly free to procure a high-priced safe abortion without fear of criminal sanction. This discrimination is therefore far more than an unequal side-effect of an otherwise equal law. The law itself is unequal. It is a *direct* discrimination against the poor, a gross violation of this country's "pledge of the protection of equal laws." Yick Wo v. Hopkins, 118 U.S. 356, 369, 68 S.Ct. 1064, 1070, 30 L.Ed. 220 (1886). Moreover, since the discrimination affects the most fundamental human rights —either by denying abortion to the poor altogether or by subjecting them unequally to risks of life and limb—"*strict* scrutiny * * * is essential, lest *unwittingly, or otherwise* invidious discriminations are made against groups or types of individuals in violation of the constitutional guarantee of just and equal laws." Skinner v. Oklahoma, 316 U.S. 535, 541, 62 S.Ct. 1110, 86 L.Ed. 1655 (1942) (compulsory sterilization law) (emphasis added). See also note 32, *supra*. Many women lose the use of their sexual organs as a result of the abortion laws, see note 31, *supra*, just as did the habitual criminals in *Skinner*. I would hold the statute invalid on the ground of equal protection alone.

(4) The abortion statute neither has a clear purpose to protect fetal life, nor is there good reason to believe it significantly does so in fact. (except, perhaps, where the poor are concerned). See "Conclusions (1) and (3)," *supra*, text at notes 26–29, *supra*, Abortion and the Law 23 (Smith ed. 1967); *Cf.* Griswold v. Connecticut, *supra*, 381 U.S. at 498, 85 S.Ct. at 1689.[34]

These, then, are the weighty State "interests" for which the mother must suffer and, in an estimated 8,000 cases last year, die. I must dissent.[35]

32. "And the clear *effect* of these statutes, *as enforced*, is to deny disadvantaged citizens of Connecticut, those without either knowledge or resources to obtain private counseling, access to medical assistance and up-to-date information in respect to proper methods of birth control * * *. In my view, a *statute with these effects bears a substantial burden of justification when attacked under the Fourteenth Amendment.* Yick Wo v. Hopkins, 118 U.S. 356, 6 S.Ct. 1064, 30 L.Ed. 220 * * * Skinner v. State of Oklahoma, 316 U.S. 535, 62 S.Ct. 1110, [86 L.Ed. 1655] * * *." (emphasis added) (concurring opinion of Justice White)

33. "* * * strict scrutiny * * * is essential, lest *unwittingly or otherwise* invidious discriminations are made against groups or types of individuals in violation of the constitutional guarantee of just and equal laws. * * *" (emphasis added).

34. "[The State] says that preventing the use of birth-control devices by married persons helps prevent the indulgence by some in such extra-marital relations. The rationality of this justification is dubious, particularly in light of the admitted widespread availability to all persons in the State of Connecticut, unmarried as well as married, of birth control devices * * *." (concurring opinion of Justice Goldberg).

35. "But, as might be expected, we are not presented simply with this moral judg-

I attach as an appendix portions of the excellent opinion of Judge Clarence P. Cooper, which is otherwise not reported.

APPENDIX

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT OF THE STATE OF SOUTH DAKOTA, WITHIN AND FOR PENNINGTON COUNTY

STATE OF SOUTH DAKOTA,
Plaintiff,
vs.
H. BENJAMIN MUNSON,
Defendant

MEMORANDUM DECISION

April 6, 1970

CLARENCE P. COOPER, Circuit Judge:

"* * * most of the abortion laws were passed in the so called 'Victorian' era, a time when moral and religious fervor against anything regarded as sinful, resulted in many laws governing morals and personal conduct. The South Dakota statute dates back to 1877. Most of these laws governing personal or private conduct, like the 'blue laws' have either been repealed or have not been enforced. The laws prohibiting abortion represented a change from the common law which permitted abortion in the initial stages of pregnancy, before quickening of the fetus. * * *

"According to reliable estimates, more than a million American women had abortions last year. Of these about 350,000 needed hospital care when they attempted to abort themselves, and more than 8000 of these self-help cases died. (Life Magazine, Feb. 27, 1970) Enforcement of the abortion laws has been chiefly against quacks and charlatans who have botched the job, and the woman lived to complain. Where death ensues, the prosecution has been for homicide. It is a rare case when a licensed physician has been prosecuted. In no instances has the woman been prosecuted, although the abortion laws are directed equally against the woman seeking an abortion.

"With such massive disregard for the abortion law, reflecting a radical change in public attitude, it is in order to determine whether the exercise of the police power in prohibiting abortion is 'sanctioned by usage, held by prevailing morality to be necessary to public welfare, or endangers the vital interests of society', criteria which over the years have been used to measure the right of the State to regulate personal and private conduct. * * *"

ment to be passed on as an abstract proposition. The secular state is not the examiner of consciences: it must operate in the realm of behavior of overt actions, and where it does so operate, not only the underlying moral purpose of its operations, but also the *choice of means* becomes relevant to any Constitutional judgment on what is done. The moral presupposition on which appellants ask us to pass judgment could form the basis of a variety of legal rules and administrative choices, each presenting a different issue for adjudication." Mr. Justice Harlan, dissenting, Poe v. Ullman, 367 U.S. 497, 547, 81 S.Ct. 1752, 1779, 6 L.Ed.2d 989 (1961).

Item No. 28

IN THE CIRCUIT COURT OF THE COUNTY OF ST. LOUIS

STATE OF MISSOURI

SAMUEL U. RODGERS, M.D.; DAVID ROTHMAN, M.D.; DAVID HALL, M.D.; DAN L. BERGER, M.D.; RAYMOND B. BRAGG; ALVAN D. RUBIN; ROBERT H. CRAFT; GWYNDOLYN HARVEY; SUSAN HALVERSTADT; and SALLY STEINBACH, Plaintiffs, vs. JOHN C. DANFORTH, Attorney General of the State of Missouri; and GENE McNARY, Prosecuting Attorney of St. Louis County, Missouri, Defendants, and INFANT DOE; and M. H. BACKER, JR., M.D., Guardian Ad Litem, Defendant Intervenors.	Cause No. 315512 Equity Division

ORDER AND DECREE

Plaintiffs' Motion for Summary Judgment sustained.

I The Court finds and declares:

Section 559.100 of Missouri Revised Statutes unconstitutionally vague and indefinite, on its face and as applied; the statute as applied and interpreted does not give sufficient warning or guidance to plaintiffs, to Judges and to juries in answer to the question when may a pregnancy be terminated or interrupted - "unless the same be necessary to preserve her life".

A statute which is stated in terms so vague that men of ordinary intelligence must guess at its meaning and differ as to its application, violates "Due Process of Law".

II Section 559.100, Missouri Revised Statutes, is in deprivation of rights protected by the First, Fourth, Fifth, Ninth and Fourteenth Amendments of the United States Constitution, specifically:

(a) The right to give and to receive medical advice and treatment.

(b) The right to privacy.

(c) The right to choose whether and when to bear and rear children.

III Missouri Revised Statutes, Section 559.100, denies to plaintiffs the equal protection of the laws.

III Patients and physicians are treated differently, depending upon the local composition of the enforcing authorities and the interpretation of the phrase "unless the same is necessary to preserve her life", i.e., a pregnancy resulting from rape, incest, deformity, or one which may endanger the mental or physical health of the mother.

There is no overriding or compelling State interest to justify the differences.

The statute deprives women of their rights to determine, with their physicians, whether or not to carry a pregnancy to term.

IV Section 559.100 of the Missouri Revised Statutes is in conflict with the "Due Process of Law" under the Fourteenth Amendment of the United States Constitution in that it does not provide an official method by which a physician, patient, or hospital Theraputic Abortion Committee can obtain a timely or adequate review of a decision on the legality of an abortion.

V The moral, religious, and philosophical aspects of the law of abortion are not possible of solution or agreement. Those whose moral, religious, or philosophical convictions do not allow or provide for abortion under any circumstances may follow the dictates of their own beliefs and conscience; and those whose philosophical, moral, or religious beliefs provide otherwise may do so without fear of criminal prosecution - there being no overriding or compelling public or State interest. A different solution in my judgment would impose the will or one moral, religious and philosophical conclusion upon another in violation of the First Amendment of the United States Constitution.

WHEREFORE, the Court sustains plaintiffs' Motion for Summary Judgment.

June 7, 1971

/s/ Herbert Lasky
Herbert Lasky, Judge
Division 4

Item No. 29

IN THE MUNICIPAL COURT OF THE CENTRAL ORANGE COUNTY JUDICIAL DISTRICT

COUNTY OF ORANGE, STATE OF CALIFORNIA

PEOPLE OF THE STATE OF CALIFORNIA Plaintiff vs. Dr. John Shriver Gwynne Deborah T. Dwyer Defendants	CASE 173309 OPINION June 16, 1970

Defendants, one of them a licensed practicing medical doctor, have been charged with two counts of violation of Section 274 of the Penal Code, by intentionally procuring miscarriages not in compliance with Chapter 11 of Division 20 of the Health and Safety Code.

Defendants and both of them have demurred to the complaint on the grounds that the complaint fails to state a cause of action or crime, in that Section 274 of the Penal Code and Sections 25950 and following sections of the Health and Safety Code are in violation of the Constitution of the United States and of California.

For purposes of the demurrer, the court presumes the charges in the complaint to be true.

There have as yet been no appellate decisions with respect to these sections, so the court must take up one by one the general objections raised in defendants' briefs.

To satisfy the First Amendment establishment clause, the Constitution requires a secular legislative purpose and a primary effect that neither advances nor inhibits religion. ***Everson v Board of Education; McGowan v Maryland.***

The stated purpose of the combination of sections in question is a medical one, purely secular. In construing legislation in California, one may look to the title, etc. Here the primary sections are placed in the Health & Safety Code and are entitled "Therapeutic" and

the primary effect is upon the health of the mother, which neither advances nor inhibits her religious faith.

The Court would have handled this issue out of hand except for the fact that the greater part of argument was had in this area.

I think it appropriate, here, to say a word regarding the blatant attack made by the defense upon the Supreme Court.

A casual reading of the ***Belous*** case would satisfy even the most prejudiced man that both the opinion of Justice Peters and the dissents of J. Burke and J. Sullivan are directed entirely to the legal questions involved, particularly vagueness, and I for one can find not one scintilla of evidence to substantiate the claim of defense counsel.

I consequently believe that defense argument shows a bigotry unworthy of a court of law.

It is urged that there is no such thing as a "Right of Privacy" in a woman either under the Ninth Amendment or the Fourteenth Amendment, with regard to the bearing of children, etc.

Whatever the merits of this contention, the California Supreme Court has said,

> "The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a 'Right of Privacy' or 'liberty' in matters related to marriage, family, and sex." ***People v Belous***

This court is bound by that statement of law.

Therefore, to regulate in this area the State must have a compelling or overriding interest in the regulation of the subject which is within its police powers.

It has been urged in other states and cases that the State has such an interest in an unborn fetus. None has been found in California prior to viability. (***Keeler v Superior Court*** and ***People v Belous)*** The recent Supreme Court opinion in the ***Keeler*** case may even cast doubt on the interest after viability.

However, we are not here concerned with such an interest, if any there is, because the Legislature has clearly framed the interest upon which it relies; (to-wit: the health of the mother.) The Legislature showed no interest in the unborn fetus prior to twenty weeks by permitting abortion in cases of rape and incest, etc. As Judge Mast stated in the *Robb* case: "If life were present at conception, abortions would not be permitted in cases of rape or incest any more than it would be permitted to terminate the life of a one-year old whose life had come as the result of rape or incest."

Regarding, then, the health of the mother as the only interest of the State involved in these statutes; the statement in *People v Belous* that "abortions are 'the most common single cause of maternal deaths in California,'" and "abortions early in pregnancy and properly performed present minimal danger to the woman;" along with the explanatory material cited therein, gives the State a sufficient and compelling interest in the regulation of abortion to allow the Legislature to proscribe that abortion only be done by a physician, in an accredited hospital, prior to twenty weeks and after consultation or approval of a number of staff doctors. These regulations appear to the court to be reasonable in view of the compelling interest of the State in the life and health of its women residents. To say otherwise would be to merely substitute the court's opinion for that of the Legislature and I cannot do that.

Health & Safety Code Section 25951 and subsections a and b satisfies Constitutional requirements and are valid regulations.

Sub-section c, however, prohibits abortion unless certain conditions are found to exist. Sub-section c(2) attempts to distinguish pregnancy resulting from rape and incest from other pregnancy and in doing so violates the equal protection clause of the Fourteenth Amendment.

"A Statute makes an improper and unlawful discrimination if it confers particular privileges upon a class arbitrarily selected from a larger number of persons, all of whom stand in the same relation to the privilege granted and between whom and persons not so favored, no reasonable distinction or substantial difference can be found justifying the inclusion of one and the exclusion of the others." *Franchise Motor Freight Association v Seavey.*

Classes excluded from the statute include those whose potential offspring are likely to bear grave disabilities, either mental or physical, as a result of the condition of the mother early in the pregnancy, and which are at least as compelling when viewed from the standpoint of the health and welfare of the mother as those following rape or incest. Such discrimination is improper and cannot stand. Likewise, Section 25952, which sets forth procedures to follow in cases of rape and incest, is rendered unnecessary.

I disagree with Judge Mast with regard to his application of the Fifth Amendment right against self-incrimination to Section 25952, in view of the immunities granted therein; however, a decision in that area is not necessary in view of the basic ruling hereinbefore stated.

We come, then, to the most basic question presented. Sub-section c(1) of Section 25951 limits abortion to those cases which "gravely impair the physical or mental health of the mother" or at least where there is a "substantial risk" thereof.

The Court here must balance the risks between the State interest in health and the Right of Life and Liberty in the Fourteenth Amendment.

A hospital abortion performed under clinical conditions during the first semester of pregnancy is a safe and simple procedure. In fact, it is now actually safer for a woman to have a hospital abortion than to bear a child. A woman has a compelling interest in her own health and indeed in her life, as well as does the State.

This statute goes beyond protecting women from unsafe procedures and unlicensed practitioners and into the area of impermissible overbreadth.

Under police power, the state can regulate abortion, as the Court has earlier stated; however, it may not deny to a woman the basic right reserved to her under the Fourteenth Amendment to decide whether she should carry or reject an embryo which has not yet reached the twentieth week. Sub-section c(1) of Section 25951 of the Health & Safety Code suffers from fatal overbreadth.

The Court believes that Section 25951 of the Health & Safety Code, Sub-sections a and b are severable from Sub-section c and may stand alone along with Section 25953.

The Court, therefore, sustains the demurrer and grants the People ten days leave to amend their complaints to set forth sufficient particularities so as to give notice to defendants regarding against what they must defend themselves.

/s/ William W. Thomson
Judge

Dated: June 16, 1970

Item No. 30

IN THE MUNICIPAL COURT OF THE CENTRAL ORANGE COUNTY JUDICIAL DISTRICT

COUNTY OF ORANGE, STATE OF CALIFORNIA

PEOPLE OF THE STATE OF CALIFORNIA)		
Plaintiff)	CASE 149005 CASE 159061	
v.)		
ROBERT CUMMING ROBB,)	OPINION OF THE COURT	
Defendant)		

The defendant, Robert Cumming Robb, a medical doctor licensed to practice medicine in the State of California, stands before the Court charged with felonies in four counts. The People of the State of California charge in Count I of Complaint 149005, filed September 4, 1969, that Dr. Robb violated on the twenty-sixth day of November, 1968, Section 274 of the Penal Code of the State of California in that in Orange County, California, he wilfully, unlawfully and feloniously provided, supplied and administered to Susan Klambara and procured said Susan Klambara to take medicine, drugs and substances, and use and employ an instrument and other means with intent thereby to procure a miscarriage of Susan Klambara, which was not in compliance with the Therapeutic Abortion Act, Chapter 11 of Division 20 of the Health and Safety Code of the State of California.

The People charge in Count II of said complaint a violation of the same statute on the twelfth day of August, 1969, in relation to the intentional miscarriage of Teri Ann Alesandro.

The People charge in Count I of Complaint 159061, filed December 22, 1969, violation of the same statute on the thirtieth day of October, 1969, in relation to the intentional miscarriage of Linda P. Muschetto; and in Count II of said complaint the violation of the same statute on the twenty-ninth day of November, 1969, in relation to the intentional miscarriage of Darice Lombard.

By these two complaints, which have been consolidated, the People charge Dr. Robb with four counts of abortion in violation of what is commonly referred to as the "Therapeutic Abortion Act of 1967."

The defendant, Dr. Robb, has demurred to the complaint and seeks to have the complaint dismissed on the grounds that the complaint fails to state a crime in that Penal Code Section 274 (The Therapeutic Abortion Act of 1967) is in violation of the Constitution of the United States.

In considering this demurrer we must, and we do, assume that the charges alleged in the complaints are true.

The "Therapeutic Abortion Act of 1967," Section 274 of the Penal Code states:

> Every person who provides, supplies or administers to any woman, or procures any woman to take any medicine, drug or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, except as provided in the Therapeutic Abortion Act, Chapter 11 (commencing with Section 25950) of Division 20 of the Health and Safety Code, is punishable by imprisonment in the state prison not less than two nor more than five years."

Chapter 11 of the Health and Safety Code stated in general that a licensed doctor may perform an abortion if:

First, the operation takes place in a hospital which is accredited by the Joint Commission on Accreditation of Hospitals:

Second, the abortion is approved in advance by a committee of the medical staff of the hospital, which committee is established and maintained in accordance with standards promulgated by the Joint Commission on Accreditation of Hospitals; and

Third, the Committee of the Medical Staff finds that either there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or the pregnancy resulted from rape or incest.

Mental health is defined as mental illness to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint.

Further, the Act provides that upon the receipt of an application for an abortion on grounds that the pregnancy resulted from rape or incest, the Committee

shall immediately notify the district attorney of the county in which the alleged rape or incest occurred, and transmit to said district attorney the affidavit of the applicant attesting to the facts establishing the rape or incest.

This is a case of first impression. There has not been any trial or appellate court in the State of California which has considered the constitutionality of the "Therapeutic Abortion Act of 1967." Nor has there been any prior consideration in any of the American jurisdictions of any law similar to the present California law.

The court is mindful of the cases of People of the State of California v. Leon Phillip Belous, 71 A.C. 996, and United States of America v. Milan Vuitch, United States District Court for the District of Columbia Nos. 1043-68 and 1044-68. These two cases considered the law prior to 1967 in California, and a similar law in the District of Columbia.

People v. Belous held that the term "necessary to preserve" (the life of the woman) used in the law as it existed prior to 1967 was not sufficiently certain to satisfy the due process requirements of fundamental constitutional rights. The Court pointed out that no one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes, and that all are entitled to be informed as to what the State commands and forbids.

The Court further states that a woman has a right to life and to choose whether to bear children. The woman's right to life is involved because childbirth involves risks of death.

The right of the woman to choose whether to bear children follows from the United States and California Supreme Courts' acknowledgment of a right of privacy or liberty in matters related to marriage, family and sex.

The Court points out that the critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state.

The case of United States v. Vuitch considers a statute in which the phrase "as necessary for the preservation of the mother's life or health." The Court adopts the opinion of People v. Belous so far

as the same language is considered and in addition holds the word "health" is uncertain.

Thus we see that both People v. Belous and United States v. Vuitch were decided upon the narrow grounds of ambiguity and uncertainty of the language of the statute. As such they have sidestepped and avoided the primary constitutional issues leading to the ultimate question of whether a legislature may in 1970 enact any law prohibiting the performance of an abortion by a medical doctor. The Court believes that this Court, as well as other courts, in view of the thousands and perhaps millions of lives profoundly affected by such laws, can no longer avoid, but must now face this ultimate question, as well as the specific questions relating to this particular statute. The Court will do so now.

The Act provides, among others, that a woman may obtain an abortion if her pregnancy resulted from incest. Incest is a crime punishable by imprisonment in the State Penitentiary for from one to fifty years (Penal Code Section 285). In order to qualify for an abortion under this section of the Act, a woman must admit that she has committed incest to her physician. In addition, pursuant to the statute, she must sign an affidavit that she has in fact committed incest, and naming the date the act occurred and the man with whom the act occurred. Further, the form in general use, pursuant to the Act, calls for "a true description of the events, complete with time, date and location."

The information submitted is required to be submitted to the District Attorney's Office. Of what possible use can this information be put to except for prosecution? Clearly none.

This Court will not hear the People claim that although it appears to be incriminatory on its face it in fact is not because they do not prosecute women for this offense. To do so would force the courts to declare the incest statute unconstitutional in that although apparently constitutional on its face, the practice of enforcement would be a clear violation of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution inasmuch as an arbitrary classification is made in practice; that is, men are treated differently than women. Both the man and the woman involved in an incestuous relationship must be treated equally.

The Court concludes, therefore, that this section violates the privilege against self-incrimination and is in violation of the Fifth Amendment of the United States Constitution.

In order for the defendant to assert as a defense this ground of unconstitutionality, must it be shown that the alleged victims in these cases became pregnant as a result of incestuous relationships? Clearly not. To require the defendant to inquire at all would be to require the violation of the Fifth Amendment protection. Thus the entire statute must fall.

Even though it is not the defendant's Fifth Amendment privilege which is being violated, he is clearly a proper person to assert the privilege in this case, in accordance with numerous recent decisions of the United States and California Supreme Courts.

The next question is whether the authority delegated by the Legislature to the Joint Commission of Accreditation of Hospitals and to the Committee of the Medical Staff of individual hospitals is a proper delegation of legislative authority. In order to be proper, definite and certain guidelines must be set forth so that the person exercising the authority knows exactly what the legislature intended, and so that the courts can review the exercise of authority.

In this statute there are virtually no established standards to limit the authority. What words of the statute there are which it might be argued set standards are so vague as to be completely meaningless. (This will be discussed further in considering the problem of vagueness.)

Improper delegation of legislative authority in the case of this statute leads to a far greater fault in the statute: The violation of the Equal Protection Clause of the Fourteenth Amendment.

The cases are now clear that in considering the Equal Protection Clause we look to the practice and effect of the statute not the mere face of the statute. What is the practice and effect here? It is that there is a distinct disparity of treatment and operation of the law in different geographic areas of the state.

This can only be the result of improper delegation of legislative authority. We see that in an area which accounts for 16 per cent of the live births, 50 per cent of the abortions are performed, whereas in an area of the state which accounts for 50 per cent of the live births, 23 per cent of the abortions are performed. Such unequal treatment cannot be tolerated.

The Court finds also that there is a pronounced disparity of treatment between the rich and the poor, which is an improper, arbitrary classification, clearly violative of the Equal Protection Clause. The percentage of rejected applicants is far greater in "charity" or indigent hospitals than it is in private hospitals. The rich can "purchase," by consultation fees, letters from the necessary psychiatrists to support their applications -- the poor cannot. The result is that the rich can arrange for abortions under the present law almost at will. The poor cannot.

The Constitution of the United States does not, and the People of the United States will no longer countenance nor permit the unequal treatment of individuals based on their economic positions. All persons, regardless of their financial standing, must be treated equally, and any law not so treating them cannot stand. The time is past when this community - The United States - can or will tolerate arbitrary discrimination or unequal application of the laws.

The next issue I wish to consider is whether the statute is in any way vague or uncertain. A criminal statute must be definite and certain enough to apprise the public as to what acts are prohibited. Failing this, the statute is in violation of the Due Process Clause of the Fourteenth Amendment. For the most part, the statute is definite and certain. However, that part which refers to mental illness "to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint," is completely without meaning and offers no guide whatsoever by which a person can determine what is permitted and what is prohibited. Does supervision mean in an institution, by a psychiatrist, at home? What does dangerous to herself mean? What does restraint mean? They have no meaning certain enough to apprise a person what conduct is prohibited. In addition the Court notes that these words are in the disjunctive, which compounds the vagueness.

This brings us to the primary underlying problem. Does a woman have a constitutional right to make a free choice whether or not to bear children, i.e., whether or not to have an abortion? The Constitution of the United States is strong and lasting because it was written, intentionally, in such a way as to guarantee certain basic freedoms yet to be able to expand and develop to meet changing times, attitudes and approaches. The framers of the Constitution recognized that a constitution stiff and unbending could not long endure. They, therefore, framed, and Thomas Jefferson most clearly pointed out, a Constitution which would be able to develop to protect societies of which they could not dream. We are, therefore, faced with an area which might have been proper for legislation at the inception of the laws regulating abortions in 1850, but is no longer permissible in 1970, People v. Belous, supra.

Griswold v. Connecticut, 38 U.S. 479, states quite correctly that the People of the United States have certain non-enumerated fundamental rights. That among these are a right of privacy and a right to conduct interpersonal relationships between individuals in such a manner as the individuals choose.

This Court rules, that unless the State has a compelling state interest which permits it to interfere in this area, that the total freedom of choice as to whether or not to bear children, including the unrestricted right to have an abortion, is such a fundamental right, see also People v. Belous, supra.

At the inception of the old abortion law in 1850, the State had a compelling state interest in the preservation of the health of women involved. Abortion operations were dangerous with a high incidence of infection and death resulting. Due to the advance of medical science, this is no longer true. An abortion, properly done, is one of the safest operations with virtually no incidence of fatality. There is less danger to a woman from an abortion than from carrying the pregnancy to birth. Thus this state interest is no longer present.

It has been suggested that there is a state interest in preserving the morals of the state and controlling promiscuity. Besides the obvious fact that laws such as this have no effect whatsoever on sexual attitudes of the community, the Griswold case makes it clear that private sexual relations are beyond the purview of the state. The state has no compelling interest in controlling promiscuity.

The state no longer has, if it ever had, a compelling interest in increasing the population of the state. We need not consider this argument further, as the decision is abundantly clear.

Item No. 31

IN THE MUNICIPAL COURT FOR THE SAN LEANDRO-HAYWARD
JUDICIAL DISTRICT, COUNTY OF ALAMEDA
STATE OF CALIFORNIA
BEFORE THE HONORABLE T.L. FOLEY

The People of the State of California,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Decision on Demurrer
	)	
Robert W. Barksdale,	)	
	)	
Defendant	)	
	)	

- - -

In the Barksdale matter, in view of the fact that either side might take an appeal, regardless of which way the Judge might rule, I think that the decision should be read into the record.

The defense Counsel on behalf of Dr. Barksdale filed a very thorough brief of 38 pages and went into the constitutional questions very thoroughly. He did a masterful job on the law of this case.

I was very disappointed that yesterday afternoon the District Attorney's office didn't even file a brief but handed me a copy of the brief that the Attorney General filed in People of the State of California versus Leon Phillip Belous, which doesn't pertain at all to the problem before the Court. The Belous case happened prior to the Amendments of the 1967 Abortion Act. There are many things in the Belous case that applies to the present case, but there was no brief filed on behalf of the District Attorney. Regardless of that, the Court is of the same opinion stated in the decision of Paul G. Mast, Presiding Judge of the Orange County Municipal Court, on January 9, 1970. I would like to write my own written opinion; however, in view of the time emergency in the matter of not getting the brief until yesterday afternoon I was unable to do it, but I want this in the record.

The defendant, Robert W. Barksdale, is charged with a violation of The Therapeutic Abortion Act of 1967. He has demurred to the Complaint and seeks to have the Complaint dismissed on the grounds the Complaint

fails to state a crime in that Penal Code Section 274 (The Therapeutic Abortion Act of 1967) is in violation of the Constitution of the United States.

In considering this demurrer I must, and I do, assume that the charges alleged in the Complaint are true.

The "Therapeutic Abortion Act of 1967" Section 274 of the Penal Code states:

> Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, except as provided in the Therapeutic Abortion Act, Chapter 11 (commencing with Section 25950) of Division 20 of the Health and Safety Code, is punishable by imprisonment in the state prison not less than two nor more than five years.

Chapter 11 of the Health and Safety Code stated in general that a licensed doctor may perform an abortion if:

First, the operation takes place in a hospital which is accredited by the Joint Commission on Accreditation of Hospitals;

Second, the abortion is approved in advance by a committee of the medical staff of the hospital, which committee is established and maintained in accordance with standards promulgated by the Joint Commission on Accreditation of Hospitals; and

Third, the Committee of the Medical Staff finds that either there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or the pregnancy resulted from rape or incest.

Mental health is defined as mental illness to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint.

Further, the Act provides that upon the receipt of an application for an abortion on grounds that the pregnancy resulted from rape or incest, the Committee shall immediately notify the district attorney of the

county in which the alleged rape or incest occurred, and transmit to said district attorney the affidavit of the applicant attesting to the facts establishing the rape or incest.

This is a case of first impression. There has not been any trial or appellate court in the State of California which has considered the constitutionality of the "Therapeutic Abortion Act of 1967." Nor has there been any prior consideration in any of the American jurisdictions of any law similar to the present California law.

The court is mindful of the cases of People of the State of California vs. Leon Phillip Belous, 71 A.C. 996, and United States of America vs. Milan Vuitch, United States District Court for the District of Columbia Nos. 1043-68 and 1044-68. These two cases considered the law prior to 1967 in California, and a similar law in the District of Columbia.

People vs. Belous held that the term "necessary to preserve" (the life of the woman) used in the law as it existed prior to 1967 was not sufficiently certain to satisfy the due process requirements of fundamental constitutional rights. The Court pointed out that no one may be required at peril of life, liberty or property to speculate as to the meaning of penal statutes, and that all are entitled to be informed as to what the State commands and forbids.

The Court further states that a woman has a right to life and to choose whether to bear children. The woman's right to live is involved because childbirth involves risks of death.

The right of the woman to choose whether to bear children follows from the United States and California Supreme Court acknowledgment of a right of privacy or liberty in matters related to marriage, family and sex.

The Court points out that the critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the State.

The case of United States vs. Vuitch considers a statute in which the phrase "as necessary for the preservation of the mother's life or health." The Court adopts the opinion of People vs. Belous so far as the same language is considered and in addition holds the word "health" is uncertain.

Thus we see that both People vs. Belous and United States vs. Vuitch were decided upon the narrow grounds of ambiguity and uncertainty of the language of the statute. As such they have sidestepped and avoided the primary constitutional issues leading to the ultimate question of whether a legislature may in 1970 enact any law prohibiting the performance of an abortion by a medical doctor. The Court believes that this Court, as well as other courts, in view of the thousands and perhaps millions of lives profoundly affected by such laws, can no longer avoid, but must now face this ultimate question, as well as the specific questions relating to this particular statute. The Court will do so now.

The Act provides, among others, that a woman may obtain an abortion if her pregnancy resulted from incest. Incest is a crime punishable by imprisonment in the State Penitentiary for from one to fifty years (Penal Code Section 285). In order to qualify for an abortion under this section of the Act, a woman must admit that she has committed incest to her physician. In addition, pursuant to the statute, she must sign an affidavit that she has in fact committed incest, and naming the date the act occurred and the man with whom the act occurred. Further, the form in general use, pursuant to the Act, calls for a "true description of the events, complete with time, date and location."

The information submitted is required to be submitted to the District Attorney's office. Of what possible use can this information be put to except for prosecution? Clearly none.

This Court will not hear the People claim that although it appears to be incriminatory on its face it in fact is not because they do not prosecute women for this offense. To do so would force the courts to declare the incest statute unconstitutional in that although apparently constitutional on its face, the practice of enforcement would be a clear violation of of the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution inasmuch as an arbitrary classification is made in practice; that is, men are treated differently than women. Both the man and the woman involved in an incestuous relationship must be treated equally.

The Court concludes, therefore, that this section violates the privilege against self-incrimination and is in violation of the Fifth Amendment of the United States Constitution.

In order for the defendant to assert as a defense this ground of unconstitutionality must it be shown that the alleged victims in this case became pregnant as a result of incestuous relationships? Clearly not. To require the defendant to inquire at all would be to require the violation of the Fifth Amendment protection. Thus the entire statute must fall.

Even though it is not the defendant's Fifth Amendment privilege which is being violated, he is clearly a proper person to assert the privilege in this case, in accordance with numerous recent decisions of the United States and California Supreme Court.

The next question is whether the authority delegated by the Legislature to the Joint Commission of Accreditation of Hospitals is a proper delegation of legislative authority. In order to be proper, definite and certain guidelines must be set forth so that the person exercising the authority knows exactly what the legislature intended, and so that the courts can review the exercise of authority.

In this statute there are virtually no established standards to limit the authority. What words of the statute there are which it might be argued set standards are so vague as to be completely meaningless.

Improper delegation of legislative authority in the case of this statute leads to a far greater fault in the statute: The violation of the Equal Protection Clause of the Fourteenth Amendment.

The cases are now clear that in considering the Equal Protection Clause we look to the practice and effect of the statute not the mere face of the statute. What is the practice and effect here? It is that there is a distinct disparity of treatment and operation of the law in different geographic areas of the State. This can only be the result of improper delegations of legislative authority. We see that in an area which accounts for 16 per cent of the live births, 50 per cent of the abortions are performed, whereas in an area of the State which accounts for 50 per cent of the live births, 23 per cent of the abortions are performed. Such unequal treatment cannot be tolerated.

The Court finds also that there is a pronounced disparity of treatment between the rich and the poor, which is an improper, arbitrary classification, clearly violative of the Equal Protection Clause. The

percentage of rejected applicants is far greater in "charity" or indigent hospitals than it is in private hospitals. The rich can "purchase," by consultation fees, letters from the necessary psychiatrists to support their applications -- the poor cannot. The result is that the rich can arrange for abortions under the present law almost at will. The poor cannot.

The Constitution of the United States does not, and the People of the United States will no longer countenance nor permit the unequal treatment of individuals based on their economic positions. All persons, regardless of their financial standing, must be treated equally, and any law not so treating them cannot stand. The time is past when this community -- The United States -- can or will tolerate arbitrary discrimination or unequal application of the laws.

The next issue I wish to consider is whether the statute is in any way vague or uncertain. A criminal statute must be definite and certain enough to apprise the public as to what acts are prohibited. Failing this, the statute is in violation of the Due Process Clause of the Fourteenth Amendment. For the most part, the statute is definite and certain. However, that part which refers to mental illness "to the extent that the woman is dangerous to herself or to the person or property of others or is in need of supervision or restraint," is completely without meaning and offers no guide whatsoever by which a person can determine what is permitted and what is prohibited. Does supervision mean in an institution, by a psychiatrist, at home? What does dangerous to herself mean? What does restraint mean? They have no meaning certain enough to apprise a person what conduct is prohibited. In addition the Court notes that these words are in the disjunctive, which compounds the vagueness.

This brings us to the primary underlying problem. Does a woman have a constitutional right to make a free choice whether or not to bear children, i.e., whether or not to have an abortion? The Constitution of the United States is strong and lasting because it was written, intentionally, in such a way as to guarantee certain basic freedoms yet to be able to expand and develop to meet changing times, attitudes and approaches. The framers of the Constitution recognized that a constitution stiff and unbending could not long endure. They, therefore, framed, and Thomas Jefferson most clearly pointed out, a Constitution which would be able to

develop to protect societies of which they could not dream. We are, therefore, faced with an area which might have been proper for legislation at the inception of the laws regulating abortion in 1850, but is no longer permissible in 1970, People vs. Belous, supra.

Griswold vs. Connecticut, 38 U.S. 479, states quite correctly that the People of the United States have certain non-enumerated fundamental rights. That among these are a right of privacy and a right to conduct interpersonal relationships between individuals in such a manner as the individuals choose.

This Court rules, that unless the State has a compelling state interest which permits it to interfere in this area, that the total freedom of choice as to whether or not to bear children including the unrestricted right to have an abortion, is such a fundamental right, see also People vs. Belous, supra.

At the inception of the old abortion law in 1850 the State had a compelling state interest in the preservation of the health of women involved. Abortion operations were dangerous with a high incidence of infection and death resulting. Due to the advance of medical science, this is no longer true. An abortion, properly done, is one of the safest operations with virtually no incidence of fatality. There is less danger to a woman from an abortion than from carrying the pregnancy to birth. Thus this state interest is no longer present.

It has been suggested that there is a state interest in preserving the morals of the state and controlling promiscuity. Besides the obvious fact that laws such as this have no effect whatsoever on sexual attitudes of the community, the Griswold case makes it clear that private sexual relations are beyond the purview of the state. The state has no compelling interest in controlling promiscuity.

The state no longer has, if it ever had, a compelling interest in increasing the population of the state. We need not consider this argument further, as the decision is abundantly clear.

The primary contention of compelling state interest advanced on this issue is that the law is necessary to preserve the life of the unborn. This argument will not stand the test of logic, however. When is there

life present in the eyes of the law? Certainly not at conception. If there were life present at conception abortions would not be permitted in cases of rape or incest, or the other exceptions any more than it would be permitted to terminate the life of a one-year old whose life had come as the result of rape or incest. We also see no suggestions that intrauterine devices or "morning after" pills, both of which are abortive devices, are illegal.

The case of Keeler vs. Amador County Superior Court, 276 A.C.A. 324, considering the death of a 31- to 36-week fetus states that the killing of a viable fetus -- one capable of life out of the mother's womb -- (which would always occur in the third trimester of a pregnancy) can be prosecuted for murder as the killing of a human being. Before this stage, the fetus is not considered a human being or alive.

In view of these and many other examples of the law treating the embryo different from a human, we cannot permit a legislative theory which decrees that life begins at conception. To do so would be to blandly adopt the philosophy of one of the country's major religions, an act which clearly would be in violation of the First Amendment to the United States Constitution.

Thus the Court can find no compelling interest of the state, and concludes that the right to choose to bear or not to bear children is a fundamental right of the individual woman to be exercised in any manner she chooses and which may not in any way be abridged by law.

The Court concludes that the Complaint fails to state a cause of action against the defendant inasmuch as the statute is violative of the United States Constitution.

The Complaint is ordered dismissed and the defendant discharged.

I might say that I belong to the religion that was just referred to, and I dislike to render this opinion. I must follow the law under my oath as a Judge. I am a Catholic which makes it very, very difficult -- but my oath of office calls for me to follow the law as stated and set out by the Appellate Courts of this State.

Thank You.

MR. MINTZ: Thank you, very much, your Honor.

We are very happy that we find ourselves in the courtroom of a Judge who has the courage that your Honor has displayed today. We are very appreciative.

THE COURT: Thank you, Herman.

DATED: March 24, 1970

/s/ T.L. Foley
Presiding Judge

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

FILED
JUL 22 1971
Court of Appeal - First App. Dist.
CLIFFORD C. PORTER, Clerk
By _____ Deputy

PEOPLE OF THE STATE OF CALIFORNIA, Plaintiff and Appellant, v. ROBERT W. BARKSDALE, Defendant and Respondent.	1 Crim. 9526 (Muni.Ct.No. 332370-C)

Defendant Robert W. Barksdale was charged by a complaint in the Municipal Court of the San Leandro-Hayward Judicial District, with a violation of Penal Code section 274, as amended in 1957, which states:

"Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, except as provided in the Therapeutic Abortion Act, Chapter 11 (commencing with Section 25950) of Division 20 of the Health & Safety Code, is punishable by imprisonment in the state prison not less than two nor more than five years."

The Therapeutic Abortion Act, q.v., was enacted in 1967. It provides that a licensed physician and surgeon is authorized to perform an abortion in "a hospital which is accredited by the Joint Commission on Accreditation of Hospitals" (Health & Saf. Code, § 25951, subd. (a)), if such abortion is approved in advance by a committee of the hospital's medical staff under certain prescribed conditions (§ 25951, subd. (b)), and the committee finds that one or more of the following conditions exist: "(1) There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother; (2) the pregnancy resulted from rape or incest" (§ 25951, subd. (c)). On the grounds of statutory rape (Pen. Code, § 261, subd. 1) an abortion may be approved only if the girl is under the age of 15 years (§ 25952, subd. (c)). "The committee . . . must, in all instances, consist of not less than two licensed physicians and surgeons, and if the proposed termination of pregnancy will occur after the 13th week of pregnancy, the committee must consist of at least three such licensed physicians and surgeons. . . ." (§ 25953.) The act further provides that an abortion shall not be approved after the 20th week of pregnancy. (§ 25953.)

Prior to any preliminary examination, defendant generally demurred to the complaint, urging that Penal Code section 274, being violative of the Constitution of the United States, failed to state a public offense. The municipal court, stating -- "The court can find no compelling interest of the state, and concludes

that the right to choose to bear or not to bear children is a fundamental right of the individual woman to be exercised in any manner she chooses and which may not in any way be abridged by the law" -- sustained the demurrer and thereafter dismissed the complaint.

The People appealed the judgment of dismissal to the Alameda County Superior Court. (See Pen. Code, § 1466.) That court reversed, but certified "that the transfer of [the] case to the Court of Appeal appears necessary to secure uniformity of decision or to settle important questions of law." (See Cal. Rules of Court, rules 63 and 64.) We thereupon ordered the cause transferred to this court for hearing and decision.

The parties have chosen to concede in their briefs and oral argument, and at least for the purposes of this appeal, (1) that the charged abortion was performed during the first trimester (13 weeks) of the woman's pregnancy, (2) by a "licensed physician and surgeon," (3) but <u>not</u> in "a hospital which is accredited by the Joint Commission on Accreditation of Hospitals," or in any hospital.

Defendant's primary contention is stated in this manner: "California Penal Code section 274, beyond requiring that abortions must be performed by medical doctors under medically competent procedures, may not prohibit a woman from aborting her first trimester embryo or fetus." More specifically it is urged that the right of a woman to abort an early pregnancy is essentially one of the "penumbral" rights created by the First,

Third, Fourth, Fifth and Ninth Amendments, "the right of privacy as described and given effect in Griswold v. Connecticut, 381 U.S. 479, 484-485.

Principal reliance is placed by defendant upon certain dicta of People v. Belous (1969) 71 Cal.2d 954, which considered the constitutionality of Penal Code section 274, as in effect prior to its 1967 amendment. The earlier statute provided: "Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life, is punishable by imprisonment in the state prison not less than two nor more than five years." (Emphasis added.)

In Belous the California Supreme Court, divided 4 to 3, concluded that the pre-1967 section 274 was constitutionally invalid, for the reason that its language permitting an abortion only when "necessary to preserve [the woman's] life," was unconstitutionally "vague and uncertain." The court went no further in its actual holding.

We shall first discuss the effect to be given dicta of California's Supreme Court by the lesser courts of the state.

Dicta, of course, consists of things said in an opinion that are not necessary in reaching the decision of the court. (See Childers v. Childers, 74 Cal.App.2d 56, 61-62.) It is held that such "statements of conclusions not necessary to the

decision are not to be regarded as authority. . . ." (Cox v. Tyrone Power Enterprises, 49 Cal.App.2d 383, 397; see also People v. McAllister, 15 Cal.2d 519, 523; Hills v. Superior Court, 207 Cal. 666, 670.)

Nevertheless, it has been pointed out that the real criticism of dicta "goes to those portions of an opinion which assume to determine matters outside the issues and hence [are] not fully discussed and considered. . . ." (Estate of Wever, 12 Cal.App.2d 237, 239.) Where a point, although dictum, is "quite elaborately considered" (Adams v. Seaman, 82 Cal. 636, 639), or given "full consideration" (Lossman v. City of Stockton, 6 Cal.App.2d 324, 330), it will be given respectful consideration by another reviewing court. (See also San Joaquin etc. Irr. Co. v. Stanislaus, 155 Cal. 21, 28; Granger v. Sherriff, 133 Cal. 416, 417; Paley v. Superior Court, 137 Cal.App.2d 450, 460; Donnell v. Linforth, 11 Cal.App.2d 25, 29.) When the dicta is that of our state's Supreme Court this rule must be particularly applicable to its Court of Appeal.

The respect which must be shown such considered comment of the California Supreme Court was elaborated by the United States Supreme Court in Nolan v. Transocean Air Lines, 365 U.S. 293, 295. There the court found "considered [relevant] dictum" in the case of Leeper v. Beltrami, 53 Cal.2d 195. It was said: "Inasmuch as the view expressed therein by the highest court of California may be decisive of an issue critical to petitioners' claims, and inasmuch as the Court of Appeals for the Second

Circuit is charged with mandatory appellate review in the present case, that court should decide what relative weights, as authoritative sources for ascertaining California law, the New York Court of Appeals would accord to the Sears-Haro line (direct holdings of District Courts of Appeal between 1930 and 1938) and to Leeper (a considered, relevant dictum of general scope by the California Supreme Court in 1959). We set aside the judgment of the Court of Appeals and remand to that court for reconsideration of the case in light of the new factor introduced by Leeper v. Beltrami, supra."

The California Supreme Court in People v. Belous, supra, 71 Cal.2d 954, was of course speaking in the context of a law generally denying a woman's right to an abortion. It was said (p. 963): "The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a 'right of privacy' or 'liberty' in matters related to marriage, family, and sex."[1] And speaking of

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[1] The Belous court's citation of authority to this proposition follows (pp. 963-964):

"(See, e.g., Griswold v. Connecticut, supra, 381 U.S. 479, 485, 486, 500 [14 L.Ed.2d 510, 515, 516, 524, 85 S.Ct. 1678]; Loving v. Virginia (1967) 388 U.S. 1, 12 [18 L.Ed.2d 1010, 1018, 87 S.Ct. 1817] [statute prohibiting interracial marriages, violative of due process clause]; Skinner v. Oklahoma (1942) 316 U.S. 535, 536, 541 [86 L.Ed. 1655, 1657, 1660, 62 S.Ct. 1110] [sterilization laws; marriage and procreation involve a 'basic liberty']; Pierce v. Society of Sisters (1925) 268 U.S. 510, 534-535 [69 L.Ed. 1070, 1077-1078, 45 S.Ct. 571, 39 A.L.R. 468] [prohibition against nonpublic schools; same]; Meyer v. Nebraska (1923) 262 U.S. 390, 400 [67 L.Ed. 1042, 1045-1046, 43 S.Ct. 625, 29 A.L.R. 1446]

(continued)

the right of a woman to choose whether to bear children, the court stated (p. 964), "It is not surprising that none of the parties who have filed briefs in this case have disputed the existence of this fundamental right."

The court continued (p. 964): "The critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state . . ., whether the regulation is 'necessary . . . to the accomplishment of a permissible state policy' . . ., and whether legislation impinging on constitutionally protected areas is narrowly drawn and not of 'unlimited and indiscriminate sweep' . . . ."[2]

(Fn. 1 continued)

[prohibition against teaching children German language; same]; Perez v. Sharp, 32 Cal.2d 711, 715 [198 P.2d 17]; see also Custodio v. Bauer, 251 Cal.App.2d 303, 317-318 [59 Cal.Rptr. 463].) That such a right is not enumerated in either the United States or California Constitutions is no impediment to the existence of the right. (See, e.g., Carrington v. Rash (1965) 380 U.S. 89, 96 [13 L.Ed.2d 675,680, 85 S.Ct. 775] [fundamental but nonenumerated right to vote]; Aptheker v. Secretary of State (1964) 378 U.S. 500, 505-506 [12 L.Ed.2d 992, 996-997, 84 S.Ct. 1659], and Kent v. Dulles (1958) 357 U.S. 116, 125 [2 L.Ed.2d 1204, 1209, 78 S.Ct. 113] [right to travel]; Bolling v. Sharpe (1954) 347 U.S. 497, 500 [98 L.Ed. 884, 887, 74 S.Ct. 693] [right to attend federal unsegregated schools]; Otsuka v. Hite, 64 Cal.2d 596, 602 [51 Cal.Rptr. 284, 414 P.2d 412] [right to vote]; cf. Finot v. Pasadena City Board of Education, 250 Cal.App.2d 189, 199 [58 Cal.Rptr. 520].)"

(end fn. 1.)

[2] The text of the above with cited authority follows:

"The critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state (Shapiro v. Thompson (1969) 394 U.S. 618, 634 [22 L.Ed.2d 600, 615, 89 S.Ct. 1322]; Sherbert v. Verner (1963) 374 U.S. 398, 403

(continued)

The Belous co[illegible] then proceeded to discuss the several suggested "compelling" state interests in the suppression of abortions.

First considered was the unquestioned state interest in the health and well-being of the pregnant woman. It was pointed out (in the course of a scholarly study, see generally pp. 964-965) that "When California's first anti-abortion statute was enacted, any surgical procedure which entered a body cavity was extremely dangerous. Surgeons did not know how to control infection, and mortality was high. [Citation.] In 1867 Joseph Lister first published his findings on antiseptic surgery . . ., but even in 1883 the techniques he developed were condemned . . ., and as late as 1895 were not well understood or properly applied by even leaders of the medical profession. [Citations.] [¶]

(Fn. 2 continued)

[10 L.Ed.2d 965, 969, 83 S.Ct. 1790]), whether the regulation is 'necessary . . . to the accomplishment of a permissible state policy' (McLaughlin v. Florida (1964) 379 U.S. 184, 196 [13 L.Ed. 2d 222, 230, 85 S.Ct. 283]; see also, N.A.A.C.P. v. Button, 371 U.S. 415, 438 [9 L.Ed.2d 405, 421, 83 S.Ct. 328]; Bates v. Little Rock (1960) 361 U.S. 516, 527 [4 L.Ed.2d 480, 488, 80 S.Ct. 412]; Huntley v. Public Utilities Com., 69 Cal.2d 67, 74 [69 Cal.Rptr. 605, 442 P.2d 685]; Vogel v. County of Los Angeles, 68 Cal.2d 18, 21 [64 Cal.Rptr. 409, 434 P.2d 961]; People v. Woody, 61 Cal.2d 716, 718 [40 Cal.Rptr. 69, 394 P.2d 813]), and whether legislation impinging on constitutionally protected areas is narrowly drawn and not of 'unlimited and indiscriminate sweep' (Shelton v. Tucker (1960) 364 U.S. 479, 490 [5 L.Ed.2d 231, 238, 81 S.Ct. 247]; see also, Cantwell v. Connecticut (1940) 310 U.S. 296, 308 [84 L.Ed. 1213, 1220, 60 S.Ct. 900, 128 A.L.R. 1352]; In re Berry, 68 Cal. 2d 137, 151 [65 Cal.Rptr. 273, 436 P.2d 273]; In re Hoffman, 67 Cal. 2d 845, 853-854 [64 Cal.Rptr. 97, 434 P.2d 353])."

(end fn. 2.)

Although development was slow, techniques of antisepsis and asepsis became major general advances in surgery at and after the turn of the century. In due course safe procedures were developed for specific operations. Curettage, used for abortion in the first trimester, became a safe, accepted and routinely employed medical technique, especially after antibiotics were developed in the early 1940's. [Citation.] It is now safer for a woman to have a hospital therapeutic abortion during the first trimester than to bear a child."

Suggesting that the health of the pregnant woman may have been a compelling state interest bolstering the state's early anti-abortion law, the court added (p. 967): "Although we may assume that the law was valid when first enacted, the validity of the law in 1850 does not resolve the issue of whether the law is constitutionally valid today. [Citations.]"

We note the emphasis of Belous that its study indicated that the relative safety of present day medical techniques exists when the therapeutic abortion occurs during the earlier period of the pregnancy. The court strongly implied that a compelling state interest in the health of the woman, justifying a statutory proscription of abortions, does exist at some later stage of the pregnancy.

The court then discussed the dangers of so-called "criminal abortions," i.e., those prohibited by section 274 and usually performed by unlicensed persons. It was said (pp. 965-966):

"Although abortions early in pregnancy, and properly performed present minimal danger to the woman, criminal abortions are 'the most common single cause of maternal deaths in California.' [Citation.] In California, it is estimated that 35,000 to 100,000 such abortions occur each year. [Citation.]

"The incidence of severe infection from criminal abortion is very much greater than the incidence of death. The Los Angeles County Hospital alone, for example, in 1961 admitted over 3,500 patients treated for such abortions. [Citation.] Possibly more significant than the mere incidence of infection caused by criminal abortions is the result of such infection. 'Induced Illegal Abortion . . . is one of the important causes of subsequent infertility and pelvic disease.' [Citations.]

"Amici for appellant, 178 deans of medical schools, including the deans of all California medical schools, chairmen of medical school departments, and professors of medical schools state: 'These recorded facts bring one face-to-face with the hard, shocking -- almost brutal -- reality that our statute designed in 1850 to protect women from serious risks to life and health has in modern times become a scourge.'"

The Belous court also considered the argument that the state has "a compelling interest in the protection of the embry and fetus." (P. 967.) It appeared to recognize that at some stage of pregnancy the state did acquire such an interest, even to the exclusion of the conflicting right of the woman. (See pp. 967-969.) But the court made it clear that a woman's right

to choose whether to bear children must prevail over such a state right in the pregnancy's early stage.

It was not contended by the People in Belous, and it is not contended here, that any legitimate state interest requires a larger or expanding population, at least as against the right of a woman to choose whether to bear children. Such a contention, if made, would seem to run contrary to reason in the light of scientific knowledge and the world's present day and projected population problems.

It must be said that the text of Belous which we have discussed discloses thorough and thoughtful consideration of the rights of a pregnant woman, vis-a-vis the state, in the matter of abortion legislation. Under the authority we have cited, ante, and as an intermediate appellate court of this state, we feel obliged to respect the dicta of Belous and to accept it as a correct expression of the law.

Several federal district courts have paid similar respect to the discussion of Belous.

Doe v. Scott (1971) 321 F.Supp. 1385, 1388 (N.D. Illinois, E.D.), concerned an attack on the constitutionality of an Illinois statute which prohibited all abortions except those "'performed by a physician . . . in a licensed hospital . . . because necessary for the preservation of the woman's life.'" The issue presented was (p. 1390) "whether the state has a compelling interest in preventing abortions in the early stages of pregnancy . . . ." The majority of a three-judge court, relying heavily on Belous,

ruled (p. 1391): ". . . that during the early stages of pregnancy--at least during the first trimester--the state may not prohibit, restrict or otherwise limit women's access to abortion procedures performed by licensed physicians operating in licensed facilities." The pertinent statute was held unconstitutional insofar as it restricted or prohibited the "performance of abortions during the first trimester of pregnancy by licensed physicians in a licensed hospital or other licensed medical facility."

In Roe v. Wade (1970) 314 F.Supp. 1217 (N.D. Tex.) a Texas anti-abortion law was under constitutional attack. The statute made felonious any abortion not required "for the purpose of saving life of the mother." Belous was interpreted (p. 1222) as according "Freedom to choose in the matter of abortions . . . the status of a 'fundamental' right." The Texas statute was found to infringe upon this fundamental right, the three-judge court stating:

"While the Ninth Amendment right to choose to have an abortion is not unqualified or unfettered, a statute designed to regulate the circumstances of abortions must restrict its scope to compelling state interests. There is unconstitutional overbreadth in the Texas Abortion Laws because the Texas Legislature did not limit the scope of the statutes to such interests. On the contrary, the Texas statutes, in their monolithic interdiction, sweep far beyond any areas of compelling state interest." (P. 1223.)

The court recognized a probable legitimate state concern over "abortion of the 'quickened' fetus." (P. 1223.) However, it said: "The difficulty with the Texas Abortion Laws [under consideration] is that, even if they promote these interests, they far outstrip these justifications in their impact by prohibiting all abortions except those performed 'for the purpose of saving the life of the mother.'"

Belous (71 Cal.2d 954) was again relied upon by a three-judge court in Babbitz v. McCann (1970) 310 F.Supp. 293 (E.D. Wisconsin) wherein a Wisconsin abortion statute was declared violative of the United States Constitution. That statute proscribed abortions unless necessary to save the life of the mother, in which case it must be performed by a physician and, unless "an emergency prevents," in a licensed maternity hospital. The court (pp. 301, 302) quoted the following language of Belous: "'The critical issue is not whether such rights exist, but whether the state has a compelling interest in the regulation of a subject which is within the police powers of the state. . . .'" and then continued:

"Similarly, in the case at bar, we must decide whether the state of Wisconsin has a sufficiently compelling interest to justify the broad restriction on a woman's inherently personal right that is contained in § 940.04(1) and (5), Wis. Stats.

"The defendants urge that the state's interest in protecting the embryo is a sufficient basis to sustain the statute. Upon a balancing of the relevant interests, we hold that a woman's

right to refuse to carry an embryo during the early months of pregnancy may not be invaded by the state without a more compelling public necessity than is reflected in the statute in question. When measured against the claimed 'rights' of an embryo of four months or less, we hold that the mother's right transcends that of such an embryo."

"[P. 302.] Under its police power, the state can regulate certain aspects of abortion. Thus, it is permissible for the state to require that abortions be conducted by qualified physicians. The police power of the state does not, however, entitle it to deny to a woman the basic right reserved to her under the ninth amendment to decide whether she should carry or reject an embryo which has not yet quickened. The challenged sections of the present Wisconsin statute suffer from an infirmity of fatal overbreadth."

It is to be noted that Doe v. Scott, supra, Roe v. Wade, supra, and Babbitz v. McCann, supra, as well as Belous, place heavy emphasis on the woman's right to an abortion during the early period of the pregnancy. Expressly or impliedly they assert that at some point during pregnancy the woman's right must yield to the state interest in the preservation of the fetus. Roe v. Wade (314 F.Supp. 1217) suggests that this state interest becomes paramount with the "quickened fetus." And as noted, answering the argument that the state has such an interest in the protection of the embryo as to sustain an abortion statute, the court in Babbitz v. McCann stated that the

woman's right transcended that of an embryo of four months or less.

This special consideration of the law for the advanced fetus is well documented historically. Courts and Legislatures, in varying contexts, have traditionally demonstrated greater concern for the "quickened" unborn child.[3] A sampling of such authority follows. In ancient English law the killing of the fetus of a "woman quick with childe" was manslaughter; later common law provided as one of the elements of abortion murder that "the foetus [be] quickened." Without such quickening the crimes did not appear to lie. (See Keeler v. Superior Court, supra, 2 Cal.3d 619, 626.) An 1829 statute of New York provided that: "'The wilful killing of an unborn quick child, by any injury to the mother of such child, which would be murder if it resulted in the death of such mother, shall be deemed manslaughter in the first degree.'" (Idem. p. 628.) An early Wisconsin statute (Wis. R.S. 1849, ch. 133) made abortion a punishable offense only if performed upon an unborn "quick" child. A present day statute of the same state (Wis., Stats. § 940.04) provides a much greater penalty for aborting an "unborn quick child," than for an abortion on an "unborn child."

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[3] Webster's New International Dictionary (2d ed.) Unabridged, defines "quickening" as "The first motion of the fetus in the uterus felt by the mother, occurring usually about the middle of the term of pregnancy." In Keeler v. Superior Court, 2 Cal.3d 619, 624, fn. 1, the court concluded: "The average full-term pregnancy is 40 weeks."

And as we have seen, the court in Roe v. Wade, supra, 314 F.Supp. 1217, expressed the state concern over abortion of the "quickened" fetus.

From a consideration of Belous and the other authority we have referred to, we are impelled to conclude that a woman has a constitutional right to terminate her pregnancy, subject only to reasonably imposed state restrictions designed to safeguard the health of the woman, and to protect the advanced fetus.

We now direct our inquiry into the reasonableness of the restrictions imposed by the Therapeutic Abortion Act on the woman's right to an abortion.

The first question is whether the provisions requiring an abortion to be performed by a licensed physician and surgeon in a hospital accredited by the Joint Commission on Accreditation of Hospitals are reasonably calculated to safeguard the woman's health and well-being.

It is obvious that without the surgical training and expertise of a licensed physician and surgeon an abortion would endanger the health and even life of the woman; no contention to the contrary is made. But the defendant strenuously insists that the place of an abortion operation, as with any other surgical procedure, should be determined by the doctor, in consultation with his patient, uncontrolled by law and in accordance with sound and established medical procedure. He contends that the legislative requirement of a hospital unnecessarily and unreasonably abridges the constitutional right for which he here argues.

We advert again to the scholarly dissertation of Belous. There the court concluded that it was "now safer for a woman to have a hospital therapeutic abortion during the first trimester than to bear a child." (Emphasis added.) (71 Cal. 2d at p. 965.) Its studies had indicated that "in California from November 1967 through September 1968, 3,775 therapeutic [hospital] abortions were reported without a maternal death. . . ." (P. 965, fn. 7.) On the other hand, during one year alone over 3,500 women with severe infection resulting from illegal non-hospital abortions were found to have been treated in one Los Angeles hospital. (P. 966.) And such illegal non-hospital abortions were disclosed to be "'the most common single cause of maternal deaths in California.'" (P. 965.)

For obvious reasons women seeking abortions often wish to keep knowledge of this fact from others, particularly their families and friends. Given the choice of hospital or more private surroundings they would more often choose the latter, for a hospital stay with its relative lack of privacy and its attendant records is far more likely to become commonly known. Such consideration would tend to place undue pressure on the doctor to arrange an inadequate medical environment, even when his medical judgment indicates the need of a hospital situs for the operation.

We note that in Doe v. Scott, supra, 321 F.Supp. 1385, 1391, the court found a statutory requirement that a constitutionally permitted abortion be "performed by licensed physicians

operating in licensed facilities" (emphasis added) not to be unreasonably restrictive. And the court in Roe v. Wade, supra, 314 F.Supp. 1217, 1223, found a legitimate state interest "in seeing to it that abortions are performed by competent persons and in adequate surroundings." (Emphasis added.)

We conclude that the licensed "physician and surgeon" and the "hospital" requirements of the Therapeutic Abortion Act are reasonably designed by the Legislature to further the health and welfare of the pregnant woman seeking an abortion.

Pointing to the act's requirement of a hospital accredited by the Joint Commission on Accreditation of Hospitals, defendant insists that in any event this constitutes "overbreadth," and constitutional vulnerability.

We first observe that in California all hospitals must be licensed by the State Department of Public Health. (Health & Saf. Code, § 1400.) The department is required to make and promulgate reasonable rules and regulations "prescribing minimum standards of safety and sanitation [and] of diagnostic, therapeutic and laboratory facilities and equipment . . . ." (Health & Saf. Code, § 1411.) Hospitals must be periodically inspected by the department (Health & Saf. Code, § 1407), in which authority is vested to suspend or revoke a hospital license for, among other things, violation of the prescribed rules and regulations (Health & Saf. Code, § 1412).

We note further that the Joint Commission on Accreditation of Hospitals is a private body composed of members and

organizations of the medical profession. Its purpose is to maintain and supervise professional standards in accordance with its "Standards for Hospital Accreditation." While most of California's hospitals appear to be "accredited," it nevertheless appears that many, even county hospitals, lack such accreditation and are therefore unavailable for the otherwise legitimate purpose of the Therapeutic Abortion Act.

As we have concluded, a woman has a constitutional right to terminate a pregnancy subject to reasonably enacted legislative restrictions supporting legitimate state interests. By its "accredited hospital" provision the Legislature has delegated to a private organization power to determine the hospital standards under which abortions may be performed. It is established law that a Legislature may not delegate its legislative power to a private person or organization. (Carter v. Carter Coal Co., 298 U.S. 238; Schechter Corp. v. United States, 295 U.S. 495; Daigh v. Shaffer, 23 Cal.App.2d 449. See also 16 Am.Jur.2d, Constitutional Law, § 249, p. 499; 16 C.J.S., Constitutional Law, § 137, pp. 566-567; and see the authorities in those works cited.) This rule must apply with even greater force to a legislative delegation of power affecting a constitutionally guaranteed right.

It appears that an abortion is now a relatively simple and safe surgical procedure. (See discussion, People v. Belous, supra, 71 Cal.2d 954, 965-967.) Yet, although any other surgical procedure, no matter how intricate or demanding or

dangerous, may be performed in a "licensed" hospital, abortions alone must under the act be performed under the higher or different standards of an "accredited hospital."

Further, it is obvious that the "accredited hospital" provision decreases the number of hospitals available for abortion procedures. And the requirement must, in many cases, unnecessarily increase the distance to the hospital and otherwise inconvenience the physician and surgeon and his patient seeking an abortion.

We conclude that the accredited hospital provision imposes an unnecessary and unreasonable restraint upon the constitutionally guaranteed right under discussion.

We also find the act's requirement of approval of an abortion in advance by a committee of the hospital's medical staff to be without reasonable constitutional justification. The obvious principal purpose of this requirement is to assure that a statutory condition permitting an abortion, i.e., danger to the woman's health, or rape, or incest, exists. As we have shown, no compelling state interest can be found in this area. To the extent that the committee might provide additional assurance that the woman's health would not be adversely affected by the operation we also find no compelling state interest. It will reasonably be presumed that the woman's health would be considered and safeguarded by her physician and surgeon.

The act's provision that no abortion be allowed after the twentieth week of pregnancy undoubtedly rests upon legislati

consideration for the protection of the quickened fetus, as well as the greater danger to the woman attending the abortion of an advanced pregnancy. This restriction, we believe, is reasonably supported by the compelling state interests we have discussed.

No merit is found in defendant's contention that he and his patient were denied equal protection of the law. (Cf., Babbitz v. McCann, supra, 310 F.Supp. 293, 298.) And we find nothing resembling a bill of attainder in the subject statutes. Other points raised by defendant, because of the conclusions we have reached, have become moot to a determination of his appeal.

It is established law that "'When part of a statute is declared unconstitutional, the remainder will stand if it is complete in itself and would have been adopted by the legislative body had the latter foreseen the partial invalidity of the statute.'" (In re Perez, 65 Cal.2d 224, 231.) "The test of severability is whether the invalid parts of the statute can be severed from the otherwise valid parts without destroying the statutory scheme, or the utility of the remaining provisions. . . ." (Blumenthal v. Board of Medical Examiners, 57 Cal.2d 228, 238.) Applying these rules we conclude that the unconstitutional features of Penal Code section 274 and the Therapeutic Abortion Act which we have pointed out are severable from the remainder of the statutes.

We hold that Penal Code section 274 and the Therapeutic

Abortion Act are unconstitutional insofar as they purport to deny, or impose restrictions upon, a woman's right to terminate her pregnancy within its first 20 weeks by an abortion which is performed by a licensed physician and surgeon in a licensed hospital of this state.

From all of the foregoing it appears that the municipal court complaint which, among other things, by legal implication charges that the subject abortion was not performed in a hospital, does allege the commission of a public offense by defendant. The sustaining of his demurrer by the municipal court was error.

The judgment of dismissal by the municipal court is reversed.

Elkington, J.

I CONCUR:

Sims, J.

I concur and dissent. I concur in the determination that the complaint states a public offense and that, therefore, the judgment of dismissal by the municipal court must be reversed. I do not, however, concur in the majority holding that a woman has the constitutional right to terminate pregnancy by abortion subject only to the conditions that such abortion must take place within the first 20 weeks of pregnancy and that it be performed by a licensed physician and surgeon in a licensed hospital in this state; nor do I concur in the determination that Penal Code section 274 and the Therapeutic Abortion Act (Health & Saf. Code, §§ 25950-25954) are unconstitutional in the respects indicated by the majority.

The effect of the majority opinion is to remove from the Therapeutic Abortion Act, as constitutionally invalid, the requirements that an abortion may be performed only when the pregnancy would gravely impair the physical or mental health of the mother or the pregnancy resulted from rape or incest, and the requirement that an abortion must take place in an accredited hospital with the prior approval of the hospital's therapeutic abortion committee.

It should be noted, initially, that a statute is presumed to be constitutional unless its unconstitutionality clearly and unmistakably appears that all intendments are in favor of its validity, and that mere doubt is not a sufficient reason for a judicial declaration of its invalidity. (Fox etc. Corp. v. City of Bakersfield, 36 Cal.2d 136, 141; Lockheed Aircraft Corp. v.

Superior Court, 28 Cal.2d 481, 484; Jones-Hamilton Co. v. Franchise Tax Bd., 268 Cal.App.2d 343, 349; People v. Aguiar, 257 Cal.App.2d 597, 601.) As observed in United States v. Vuitch, ____ U.S. _____, _____ [28 L.Ed.2d 601, 608], "statutes should be construed whenever possible so as to uphold their constitutionality."

In People v. Belous, 71 Cal.2d 954, on whose dicta the majority opinion relies, the Supreme Court observed that it did not have to reach the issue of the constitutional validity of the Therapeutic Abortion Act because the abortion in that case had been performed prior to the adoption of the act. (At p. 973, fn. 15.) A close reading of the case indicates, however, that the reviewing court deemed that the state has a compelling interest in regulating abortions. Implicit throughout the decision is the concept that abortions may be limited by the state if the statute is sufficiently clear and narrowly drawn. I perceive that although the court had ample opportunity in Belous to strike down abortion laws in general it did not do so. Instead it simply found that Penal Code section 274, as it read when the conduct there under consideration occurred, contained vague and uncertain provisions which jeopardized its operation by placing an unfair and dangerous responsibility upon any medical practitioner who attempted to follow it.[1] (At pp. 972-973.)

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1 - Section 274 of the Penal Code then read as follows: "Every person who provides, supplies, or administers to any woman, or procures any woman to take any medicine, drug, or substance, or uses or employs any instrument or other means whatever, with intent thereby to procure the miscarriage of such woman, unless the same is necessary to preserve her life, is punishable by imprisonment in the State prison not less than two nor more than five years

In reaching its conclusion with respect to the validity of the Therapeutic Abortion Act the majority seizes upon the statement in Belous that "The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgment of a 'right of privacy' or 'liberty' in matters related to marriage, family, and sex. [Citations.]" (71 Cal.2d at p. 963.) My colleagues interpret this statement to mean that a woman has a fundamental right to have an abortion subject only to the condition that it be performed in a licensed hospital by a licensed doctor.

None of the cases cited as authority by Belous for the principle embraced in the subject statement, including Griswold v. Connecticut, 381 U.S. 479, stands for the proposition that a woman has an unqualified right to have an abortion or that she has such a right subject to appropriate medical procedures. At most these cases hold that a woman can choose whether or not she wishes to conceive a child. Adverting to Griswold, I perceive that its holding was limited to a declaration that a statute forbidding the use of contraceptives violates the right of marital privacy guaranteed by several fundamental constitutional guarantees specified in the Bill of Rights. (Pp. 484-485.)[2]

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[2] - Two of the cases cited in Belous deal particularly with the right to have offspring as a right which is basic to the perpetuation of a race. In Skinner v. Oklahoma, 316 U.S. 535, the United States Supreme Court struck down a statute of Oklahoma which provided for the sterilization of persons defined to be "habitual criminals." The court there made this statement: "We are dealing here with legislation which involves one of the basic civil

(Fn. 2 cont'd)

Contrary to the implications of the majority opinion, Belous lays great stress upon the prospective mother's health and the criteria of good medical practice as valid standards for determining whether an abortion is lawful. (At pp. 965-971.) Recognition is specifically given to the test established in the Therapeutic Abortion Act., i.e. that abortion is permissible during the first 20 weeks of pregnancy if performed by a licensed physician in an accredited hospital and if it is determined "under prescribed procedures" that there is a substantial risk that the continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the pregnancy resulted from rape or incest. (71 Cal.2d at p. 971; emphasis added.)

In Belous there is specific recognition of the necessity that an abortion be performed in a hospital providing an accepted surgical environment. The dangers posed by a non-hospital abortion were noted thusly: "Although abortions early in pregnancy, and properly performed present minimal danger to the woman, criminal abortions [i.e., those obtained other than from a physician in an accepted surgical environment] are 'the most common single cause of maternal deaths in California.' [Citation.]" (At p.

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2 - (Cont'd) rights of man. Marriage and procreation are fundamental to the very existence and survival of the race." (At p. 541.) In Loving v. Virginia, 388 U.S. 1, the United States Supreme Court declared unconstitutional a Virginia statute which prevented marriages between persons solely on the basis of racial classifications. In that case we find this statement: "Marriage is one of the 'basic civil rights of man,' fundamental to our very existence and survival." (At p. 12.) It is clear that these two cases were concerned with procreation rather than the termination of pregnancy

965 and fn. 8 at p. 965.)

In Ballard v. Anderson, 4 Cal.3d 873, the Supreme Court, although not specifically called upon to pass on the constitutional validity of the Therapeutic Abortion Act, did, by its analysis and application of the provisions of the act to the facts at hand, give its stamp of approval to the act. Thus, in Ballard, we find the following significant language: "A legal therapeutic abortion under the act may be given only if qualified medical opinion finds (1) a substantial risk that continuancy of the pregnancy will impair the mental or physical health of the prospective mother, or (2) that the pregnancy resulted from rape or incest." (At p. 879; emphasis added.)

In Ballard the question presented was whether the Therapeutic Abortion Committee of a hospital was required to consider the application of a minor for a therapeutic abortion without the consent of her parents. The reviewing court held that such consent was not necessary and that mandamus lies to compel such a committee to exercise its discretion to approve or disapprove a minor's application for abortion "according to the statutory criteria set forth in Health and Safety Code sections 25951-25954." (4 Cal.3d at p. 884.) It is reasonable to assume that the Supreme Court would not have issued the peremptory writ if it had any misgivings that the requirement of prior approval of an abortion by a committee of a hospital's medical staff was an unconstitutional provision or that the court's direction was nothing more than an idle act.

I apprehend that Belous and Ballard clearly recognize a compelling state interest in protecting the health of a pregnant mother and that the Therapeutic Abortion Act is a salutary method of insuring such protection pursuant to the state's traditional police power to restrict medical procedures to competent medical practitioners operating in sanitary facilities under safe conditions.

It should be noted here that in United States v. Vuitch, supra, ____ U.S. _____, _____ [28 L.Ed.2d 601, 610], a case decided subsequent to Belous, the United States Supreme Court held that a District of Columbia statute,[3] containing language similar to that struck down in Belous, was not constitutionally vague. Significant to the consideration of the instant discussion is the following statement in Vuitch: "The statute does not outlaw all abortions, but only those which are not performed under the direction of a competent, licensed physician, and those not necessary to preserve the mother's life or health." (At p. 608.)

In my opinion the state also has a compelling interest to protect the embryo or fetus as the center of legal rights. There is abundant and respected authority for the proposition that at some time during the period of gestation the embryo or fetus

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3 - This statute provided: "Whoever, by means of any instrument, medicine, drug or other means whatever, procures or produces or attempts to procure or produce an abortion or miscarriage on any woman, unless the same were done as necessary for the preservation of the mother's life or health and under the direction of a competent licensed practitioner of medicine, shall be imprisoned in the penitentiary not less than one year or not more than ten years; . . ."

becomes a human being entitled to the right of life. Among these are those who hold that human life begins at conception upon the thesis that the genes of the ovum and sperm have every characteristic a human being will ever have as soon as they are united. Others are of the opinion that human life begins at a time during the period of gestation when the fetus takes on a truly human appearance.

There is also abundant and respected contrary authority to the effect that the embryo or fetus is not a human being during the period of gestation, and that human life does not begin until the fetus has developed into a being that is able to live outside the uterus. Until then, say those who hold this opinion, the fetus enjoys no rights and such rights as are generally attributed to it reflect only the interest of the parents. (See People v. Belous, supra, 71 Cal.2d 954, 967-968.)

These propositions appear to be of such generalized and universal knowledge that their existence is beyond dispute so as to require that judicial notice be taken of them. (Evid. Code, § 451, subd. (f).) At the very least they are propositions whose proposals are not reasonably subject to dispute and are capable of immediate and accurate determination by resort to sources of reasonably indisputable accuracy. As such they are matters which may be judicially noticed. (Evid. Code, § 452, subd. (h).)

In the instant case the trial court in passing upon the sufficiency of the complaint took judicial notice of these conflicting viewpoints since the matters embraced therein came to

the attention of the court in its consideration of the points and authorities submitted by the parties upon the hearing of the demurrer. (See Evid. Code, §§ 453, 454, 455.) This the trial court was justified in doing since matters which must or may be judicially noticed are a part of the complaint to be read into it together with the matters contained within its four corners. (South Shore Land Co. v. Petersen, 226 Cal.App.2d 725, 742-747; Colvig v. RKO General, Inc., 232 Cal.App.2d 56, 63-64.) As indicated by the trial court in its "Decision on Demurrer" these viewpoints were considered by it. In its decision the trial court adopted as part of its rationale the proposition that life is not present in the embryo at conception and apparently adopted, as a legal proposition, the concept that the fetus is not a human being until it is capable of life out of the mother's womb.

Among the matters called to the attention of the trial court in connection with the aforementioned viewpoints as to when human life begins was evidence adduced at legislative hearings in 1962 to the effect that human life begins at the time of conception. It is inconceivable that the Legislature which enacted the Therapeutic Abortion Act in 1967 did not have before it this proposition as well as the varying and conflicting viewpoints mentioned above.

As a reviewing court, this court is justified in taking judicial notice of each matter properly noticed by the trial court. (See Evid. Code, § 459; Smith v. Hatch, 271 Cal.App.2d 39, 49.) This court is also entitled to consider the facts as they

appear on the face of the Therapeutic Abortion Act, since the construction of a statute and its applicability to a given situation are matters of law, and we are not bound by the trial court's construction. (Estate of Madison, 26 Cal.2d 453, 456; Neal v. State of California, 55 Cal.2d 11, 17; Plum v. City of Healdsburg, 237 Cal.App.2d 308, 313.)

Accordingly, it appears to me that in enacting the subject act the state clearly evinced a genuine interest and concern for the unborn. That such was the legislative intent is demonstrated by the provisions of the act which limit abortions to cases where the continuance of the pregnancy would gravely impair the physical and mental health of the mother and to those cases where the pregnancy results from rape or incest. If the Legislature had no interest in the embryo or fetus it could simply have provided that a woman was entitled to have an abortion subject only to certain approved medical procedures. The act, however, clearly outlaws all abortions except those performed according to the limitations therein delineated--limitations which Belous recognizes to be properly within the police power of the state.

It is logical to deduce from the facts as appear on the face of the enactment that it was the legislative intent to give the rights of the pregnant woman whose physical or mental health was gravely endangered or whose pregnancy resulted from rape or incest precedence over the rights of the unborn only during the first 20 weeks of pregnancy. It is also logical to deduce from

the enactment that it was the legislative intent to outlaw abortions after the 20th week of pregnancy because of the concomitant compelling interest the state has in the health and welfare of the prospective mother and the fetus she is carrying. Belous points out that a hospital therapeutic abortion is a relatively safe procedure in the first trimester of pregnancy (at p. 965), but takes cognizance that "By limiting [in the Therapeutic Abortion Act] the abortion to the first 20 weeks, the Legislature has taken into account the danger to the mother of the later abortion . . . ." (At p. 971.)

In sum, the Therapeutic Abortion Act discloses by its provisions a concern for a pregnant woman's health and the risks of death due to an abortion, a concern that a woman who is the victim of an unwanted pregnancy should not be compelled to give birth to a child so conceived, and a concern for an unborn child's right to life. All of these considerations entered into the legislative process and the resulting legislation was clearly an attempt to reconcile the rights of the prospective mother and those of the embryo or fetus as a human being entitled to life. In the specific instances in which abortions are permitted under the act the Legislature, under its prerogative to determine the wisdom or necessity of the law, has declared that the mother's rights transcend those of the embryo or fetus.

In reaching this conclusion I am not unmindful of the dictum in Belous that "There is nothing to indicate that in adopting the Therapeutic Abortion Act the Legislature was asserting an

nterest in the embryo." (71 Cal.2d at p. 971.) A reading of Belous discloses, however, that the decision does not completely reject the concept that the embryo or fetus is a center of legal rights but postulates that a pregnant woman's right to life takes precedence over any interest the state may have in the unborn. (At p. 969.)

For the reasons indicated the Therapeutic Abortion Act must be construed so as to uphold its constitutionality. The termination of pregnancy is not an unqualified right beyond regulation by the state, but subject to reasonable limitations consonant with the state's compelling interest in the health and welfare of the prospective mother and the protection of the embryo or fetus. California has imposed valid limitations in its enactment of the act. Since the act is constitutional in its entirety, it is not the province of this court to weigh the desirability of the social policy underlying it or to question its wisdom. These are purely legislative matters.

Molinari, P.J.

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA,
IN AND FOR THE CITY AND COUNTY OF SAN FRANCISCO

JOSEPH PAUL SHIVELY, M.D., Petitioner, vs. THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA, an Administrative Agency, Respondent.	No. 590333 FINDINGS OF FACT AND CONCLUSIONS OF LAW (C.C.P.,Secs. 632; 1109)

The above entitled cause came on regularly for hearing on July 16, 1968. Robert L. Lamb and Charles G. Norris appeared for Petitioner; Thomas Lynch, Attorney General of the State of California, by Gerald Carreras, Deputy Attorney General, appeared for Respondent.

The cause was submitted and heard on the pleadings, documents and records herein; the Record; Transcript of Testimony, Volumes I and II and Exhibits introduced "In the Matter of the Accusation against J. Paul Shively, M.D.," said hearing held on January 22 and 23, 1968. Said testimony and exhibit being duly filed and introduced in evidence. Respondent's Decision and Findings; Points and Authorities; Summaries and Arguments of respective counsel.

The matter was submitted to the Court for decision, and the Court being fully advised in the premises, and having rendered its decision in favor of Petitioner and against Respondent now makes the following findings of fact and conclusions of law.

FINDINGS OF FACT

1. In each instance alleged in Respondent's Accusation, as hereinafter specified, Petitioner J. Paul Shively, M.D. participated in the obtaining or performing of a therapeutic abortion at an accredited hospital with the approval of the hospital's therapeutic abortion committee in a case of proven rubella in the first trimester of the patient's pregnancy.

2. On or about August 6, 1963, Petitioner did not aid and abet a criminal abortion upon the person of Alice F. McIntosh.

3. On or about April 20, 1964, Petitioner did not

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aid and abet a criminal abortion upon the person of Diana Martin.

4. On or about April 22, 1964, Petitioner did not attempt to perform a criminal abortion upon the person of Diana Martin.

5. On or about May 18, 1965, Petitioner did not agree and offer to procure a criminal abortion upon the person of Eileen Selig.

6. On or about May 18, 1965, Petitioner did not aid and abet a criminal abortion upon the person of Eileen Selig.

7. On or about May 20, 1965, Petitioner did not attempt to perform a criminal abortion upon the person of Eileen Selig.

8. On or about May 20, 1965, Petitioner did not agree and offer to procure a criminal abortion upon the person of Sharon Signer.

9. On or about May 20, 1965, Petitioner did not aid and abet a criminal abortion upon the person of Sharon Signer.

10. On or about May 22, 1965, Petitioner did not perform a criminal abortion upon the person of Sharon Signer.

11. On or about June 9, 1965, Petitioner did not aid and abet a criminal abortion upon the person of Betty Logwood.

12. On or about May 28, 1964, Petitioner did not aid and abet a criminal abortion upon the person of Thelma Lofink.

13. Petitioner, in good faith, and with a sincere opinion that it was an acceptable standard of medical practice in the City and County of San Francisco to perform therapeutic abortions in accredited hospitals in cases of proven rubella during the first trimester where the approval of a therapeutic abortion committee was first obtained rendered said medical attention to each individual named in the Accusation against him.

14. Petitioner's conduct was influenced by the fact that the Medical Schools of the University of California, the University of California at Los Angeles, Stanford University, and the University of Southern

California, during the period of 1964 and 1965, taught, in the medical curriculum, that it was an acceptable standard of medical practice to perform therapeutic abortions in an accredited hospital in cases of proven rubella during the first trimester, when the approval of a therapeutic abortion committee was first obtained.

15. Petitioner's conduct was further influenced by the fact that a large segment of the licensed and practicing physicians and surgeons in the counties contiguous to San Francisco Bay held the same opinion as did Dr. Shively.

With respect to Petitioner's involvement as found in Causes and Action First, Second, Fourth, Fifth, Seventh, Eighth, Tenth and Eleventh of the Accusation, Petitioner was voluntarily acting, without compensation, as a member of a Therapeutic Abortion Committee as the result of Petitioner's being a staff member of an accredited hospital, in conformity with what was, in good faith, believed to be acceptable medical practice.

16. In each instance, Petitioner followed procedures and practices and complied with existing standards of acceptable medical care recognized and approved by those reasonably skilled in his profession practicing in the same community.

17. Petitioner rendered professional care, in each instance, in an honest, competent and professional manner in the exercise of his best skill and understanding in good faith, with concern for the health, life and welfare of the patient.

18. In each alleged instance, Petitioner intended and believed that the therapeutic abortion was necessary to preserve the life of the mother.

19. In each alleged instance of Petitioner's participation in the performance of a therapeutic abortion with the approval of the appropriate committee in and of an accredited hospital in cases of proven rubella in the first trimester of pregnancy, the operation was necessary to preserve the life of the mother.

20. The permanent and public record of an unjustified conviction of criminal abortion causes serious and ir-

reparable injury to Petitioner's reputation and future as a Board certified obstetrician and gynecologist.

CONCLUSIONS OF LAW

1. The statement in Business and Professions Code §2377 that a criminal abortion constitutes unprofessional conduct, refers to that activity and intent defined as the crime of abortion by Penal Code §274, as the statutes exist in 1963, 1964 and 1965 when the conduct in question occurred.

2. The abortion statute, Penal Code §274, does not mean by the words "unless the same is necessary to preserve her life" that the peril to life be imminent. It is enough that the dangerous condition be potentially present, even though its full development might be delayed to a greater or less extent. Nor was it essential that the doctor should believe that the death of the patient would be otherwise certain in order to justify him in affording present relief.

People v. Ballard, (1959) 167 Cal. App. 2d. 803, 805, 814
People v. Abarbanel (1965) 239 Cal. App. 2d 31, 34

3. The burden of establishing the criminal nature of the abortions in which Petitioner participated rests with the Respondent Board of Medical Examiners and requires a demonstration through evidence that the procedure was not necessary to preserve the life of the mother; an abortion is not necessarily, in and of itself, a criminal act.

People v. Ballard (1959) 167 Cal. App. 2d 803, 805, 814
People v. Abarbanel (1965) 239 Cal. App. 2d 31, 34

4. The criminal intent necessary to be established by Respondent Board of Medical Examiners in order to find that Petitioner was guilty is the intent to commit a criminal abortion; that is, an abortion for the purpose other than to preserve the life of the mother.

People v. Ballard (1959) 167 Cal. App. 2d 803, 805, 814
People v. Abarbanel (1965) 239 Cal. App. 2d 31, 34

5. Petitioner acted in good faith in accordance with the practices and procedures recognized and approved by those reasonably skilled in his profession in the community, then it cannot be said that the operation was not necessary to preserve the life of the patient.

6. Petitioner, exercising his best professional skill and understanding, honestly believes that the operation is necessary for the preservation of the life of the mother, he cannot be found guilty of a criminal abortion.

People v. Ballard (1959) 167 Cal. App. 2d 803, 805, 814

People v. Abarbanel (1965) 239 Cal. App. 2d 31, 34

7. Respondent's power to discipline medical practitioners is not punitive and requires an established instance of professional disservice, ignorance, dishonesty or incompetence justifying action for public protection.

8. Respondent's disciplinary authority over Petitioner as a licensed physician and surgeon justifies the proceedings and includes the power to inquire as to the facts upon which Respondent's jurisdiction depends.

9. Respondent may resolve and determine issues of fact, but can neither restrict the legal consequences thereof nor render a valid order upon an erroneous conclusion of law for to do so would exercise judicial powers reserved to the courts.

Garfield v. Bd. Med. Exam. (1950) 99 Cal. App. 2d 219, 231

Aylward v. Bd. Chiropractic Exam. (1948) 31 Cal. 2d 833, 839

10. Where an administrative decision is not based upon a determination of fact, but upon an erroneous conclusion of law, and is without the Board's authority, the order is void.

Aylward v. Bd. of Chiropractic Exam. (1948) 31 Cal. 2d 833, 839

11. Respondent's decision finds, on the basis of uncontroverted evidence, that Petitioner acted in the honest opinion that the procedures in which he participated conformed with approved medical practice, were followed by many physicians and surgeons in the community, were taught by the major medical schools in this State and were rendered due to his concern for preserving the life of the patient. Respondent's interest and authority over the subject-matter terminated upon finding facts contradicting and excluding unprofessional conduct.

12. Respondent's determination of facts set forth in the Decision rendered in Petitioner's proceeding is based upon uncontroverted evidence and testimony establish-

ing circumstances precluding Petitioner's guilt of a criminal abortion as a matter of law.

13. On the basis of the Findings of Fact Petitioner was not guilty of performing a criminal abortion in that all of the women allegedly aborted were entitled to protection under the provisions of Amendment VIII of the Constitution of the United States, and Article I, Section 6, of the Constitution of the State of California.

14. On the basis of the Findings of Fact, Petitioner was not guilty of performing a criminal abortion in that all of the women allegedly aborted were entitled to protection under the provisions of Amendment XIV of the Constitution of the United States, and Article I, Section 13, Clause 6, of the Constitution of the State of California.

First Natl. Ben. Soc. v. Garrison (D.C.1945) 58 F. Supp. 972, aff'd 155 F.2d 522
Wilson v. City of Los Angeles (1960)
In re Newbern (1960) 53 Cal.2d 786, 792

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: September 24, 1968

/s/ Andrew J. Hyman
Judge of the Superior Court

Item No. 33

IN THE CIRCUIT COURT OF COOK COUNTY
COUNTY DEPARTMENT - CRIMINAL DIVISION

PEOPLE OF THE STATE OF ILLINOIS,	)	
	)	
Plaintiff	)	
	)	NO. 69-3429
vs.	)	
	)	
SPIRO P. ANAST,	)	
	)	
Defendant	)	

MEMORANDUM OPINION

1. The defendant has been indicted in a three-count indictment charging that he "committed the offense of solicitation to commit abortion in that he did willfully and unlawfully urge, encourage and advise a female..... to have an unlawful abortion committed, in violation of Chapter 38, Secs. 8-1 and 23-1, Illinois Revised Statutes, 1967." (Each of the three counts names a different female person.)

2. Defendant has filed a 2-pronged attack upon the indictment: (1) He moves to dismiss the indictment because the statute above referred to is unconstitutional because "it is vague, inexplicable of definition and impossible to decipher"; and, (2) because even presuming the constitutionality of the statute, the indictment does not charge the offense of "solicitation to commit abortion."

3. The defendant's position on both grounds is sustained by this Court.

THE FAILURE OF THE INDICTMENT TO ALLEGE A CRIME

4. Sec. 8-1 of Chap. 38, Ill. Rev. Stat. 1967, defines solicitation as follows:

> "A person commits solicitation when, with intent that an offense be committed he commands, encourages or requests another to commit that offense."

5. The indictment charged the defendant with encouraging a female to "have an unlawful abortion committed". It is obviously impossible for the female to commit a legal abortion on herself, as the Abortion Statute, Sec. 23-1, plainly imports the commission of an abortion upon a woman by another. And, it is obvious that the indictment does not charge that the defendant encouraged or requested the female to commit the crime of abortion, merely to have "an unlawful abortion committed".

6. The statute is plain and unambiguous: A person is guilty of solicitation when he encourages or requests another *to commit the offense of abortion*. Encouraging a female to have an abortion committed, which is what the indictment charges, is nowhere made an offense by any statute. Where an indictment, information or complaint which does not define those acts allegedly committed by the defendant to be specific and definite, the indictment fails.

7. And in the instant case, where the State alleged its specifics it failed to allege any crime in accordance with any existing statute.

8. Accordingly there can be no solicitation to encourage a female "to have an unlawful abortion committed" and the indictment is void on that ground.

9. Sec. 23-1 of the Criminal Code states as follows:

> "(a) A person commits abortion when he uses any instrument, medicine, drug or other substance whatever, with the intent to procure a miscarriage of any woman. It shall not be necessary in order to commit abortion that such woman be pregnant or, if pregnant, that a miscarriage be in fact accomplished. A person convicted of abortion shall be imprisoned in the penitentiary from one to ten years."
>
> "(b) It shall be an affirmative defense to abortion that the abortion was performed by a physician licensed to practice medicine and surgery in all its branches and in a licensed hospital or other licensed medical facility because necessary for the preservation of the woman's life. 1961, July 28, Laws 1961, p. 1983, Sec. 23-1".

The statute is unconstitutional (1) for vagueness; and (2) for infringing upon a woman's right to control her body.

10. In *Lanzetta v. New Jersey,* 306 U.S. 451, the Supreme Court held that when a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess as to its meaning and differ as to its application, such statute violates the first essential of due process of law, (p. 453).

11. A similar statute was held unconstitutional by the Supreme Court of California, *People v. Belous,* 80 Cal. Reptr. 354 (1969). That court held that a statute making a person who performs an abortion punishable unless abortion is necessary to preserve a mother's life was invalid where the term "necessary to preserve" was not susceptible to a construction which was sufficiently certain to satisfy due process requirements.

12. Just as the defendant in *Belous,* who did not commit the abortion but who referred the patient to a non-physician who did, had standing to raise the constitutional question, the instant defendant likewise has standing. *Griswold v. Connecticut,* 381 U.S. 479, 481; *Barrows v. Jackson,* 346 U.S. 249, 257.

13. The court does not find any compelling state interest sufficient to override the infringement on the personal liberty of a woman effected by the statute here being challenged.

"The fundamental right of the woman to choose whether to bear children follows from the Supreme Court's and this court's repeated acknowledgement of a 'right to privacy' or 'liberty' in matters related to marriage, family and sex. *Griswold v. Connecticut,* 381 U.S. 479; *Loving v. Virginia,* 388 U.S. 1, 12; 18 L. Ed. 2d. 1010 (statute prohibiting interracial marriages held violative of the due process clause).

Recently, a three-judge court sitting in the United States District Court, Eastern District of Wisconsin (Milwaukee), headed by Judge Kerner of the Seventh Circuit Court of Appeals, held unconstitutional a somewhat similar statute (Sec. 940.04 Wis. Stats.) as the one at bar. *Babbitz, Plaintiff v. McCann, et al, Defendants,* No. 69-C-548. The three-judge court held "upon a balancing of the relevant interest, we hold that a woman's right to refuse to carry an embryo during the early months of pregnancy may not be invaded by the State without a more compelling public necessity than is reflected in the statute in question. When measured against the claimed 'right' of an embryo of four months or less, we hold that the mother's right transcends that

of such an embryo." And recently also, a District Court in the District of Columbia invalidated an abortion law in slightly different language. *United States v. Vuitch,* 38 L. W. 2275 (Nov. 10, 1969). The court in *Vuitch* observed: "There has been moreover, an increasing indication in decisions of the Supreme Court of the United States that as a secular matter, a woman's liberty and right of privacy extends to family, marriage and sex matters and may well include the right to remove an unwanted child at least in the early stages of pregnancy." Accordingly, the Illinois Abortion Statute is unconstitutional in the opinion of this Court.

CONCLUSION

16. For the foregoing reasons, this court holds the statute to be unconstitutional and further holds the indictment to be insufficient; and it is hereby dismissed.

Respectfully submitted,

/s/ George E. Dolezal, Judge
Criminal Division
Cook County Circuit Court

GED:mm

Item No. 34

IN THE COURT OF COMMON PLEAS OF CENTRE COUNTY
PENNSYLVANIA

CRIMINAL

COMMONWEALTH : No. 1968 - 353

VS. :

BARRY GRAHAM PAGE :

O P I N I O N

CAMPBELL, P.J.:

History

On October 21, 1968, the defendant, a motorcycle mechanic who acquired his expertise in the merchant marines, entered a plea of guilty to a charge that he aborted two unmarried pregnant women. He was sentenced to the state penitentiary for a term of two to five years.

The Act of June 24, 1939, P.L. 872, Section 718 (18 P.S. 4718) was the statutory basis for the prosecution. It is a "broad brush" statute prohibiting all abortions without exception within the state of Pennsylvania.

On March 4, 1970, the defendant filed a PCHA petition alleging that the aforesaid abortion statute is unconstitutional in that it violates the constitutions of Pennsylvania and the United States.

The Social Problem

The problem of abortion is a matter of great current concern in the United States. Aside from the moral and religious issues involved, the resulting social implications and effects are great. The Kinsey group have estimated that one out of every five pregnancies in the United States end in abortion. The annual take by non-professional abortionists has been estimated to be over $350,000,000 a year and is thought to be the third largest illegal endeavor in the United States, exceeded only by gambling and

narcotics. (1) It has further been estimated that over 5,000 women die each year from criminal abortions. (2) As a result of the enormous resulting problems, abortion statutes are being subjected to critical review.

State's Compelling Interest

The commonwealth is aided by the presumption in favor of the constitutionality of the statute. Aside from this presumption, courts have traditionally upheld the constitutionality of state legislation if it can establish an overriding legitimate legislative purpose to justify the interference with individual and family privacy. Thus the real question, as stated in ***People v. Belous,*** 80 Cal. Rep. 354; 38 LW 2167 (1969), was not "whether the right exists but whether the state has a compelling interest in the regulation of the subject which is within the police power of the state."

What is the state's compelling interest in the abortion statute? Is it to discourage fornication and other illicit sexual conduct? If so, why does the statute apply to both married and unmarried women?

Is the state's compelling interest the desire to preserve the health and welfare of women? Why, then, does it apply in bold fiat to medical doctors who possess the requisite skill to easily perform a safe abortion during at least the first trimester of pregnancy? There is abundant medical opinion that it is safer for a woman to have a hospital therapeutic abortion than to bear a child.

Is the state's compelling interest the desire to protect the rights of the fetus? The 14th Amendment to the U.S. Constitution requires that the state accord "due process of law" and "equal protection of the laws" to ***any person*** within their respective jurisdiction and that all ***persons born or naturalized*** in the United States and subject to the jurisdiction thereof are citizens of the United States and of the state wherein they reside. (emphasis added.) We know of no court which has construed the early development of the fetus as being a person within the meaning of the 14th Amendment and on the contrary believe that it is generally only applicable at birth. The protection of the embryo and fetus does not justify an abortion statute: ***People v. Belous, supra.***

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(1) D. Lowe, Abortion and the Law, 3-5 (1966)

(2) Bates and Zawadski, Criminal Abortion, 3-4 (1964).

We can readily perceive of a valid compelling interest of the state in the subject of abortion if it were directed, for example, to prevent an unqualified, unlicensed and untrained individual to perform an abortion which medically would jeopardize the health and safety of the woman involved but, in order to accomplish the result in which the state is interested, the statute must be sufficiently narrow in scope to serve the limited purpose involved: ***McLaughlin v. Florida,*** 379 U.S. 184; 85 S. Ct. 283 (1964); ***Shelton v. Tucker,*** 364 U.S. 479; 5 L. Ed. 2d 231 (1960).

We flatly hold that the Pennsylvania statute does not meet this standard because of its broad unlimited and indiscriminate application.

Right to Marital and Personal Privacy

We pass now to the question of whether or not the abortion statute violates the woman's fundamental right to personal privacy and, likewise, the fundamental right to marital privacy.

The Supreme Court of the United States has shown a marked concern with regard to legislative interference in the marital relationship, the individual's right to bear children and to be free from unwarranted invasion upon one's right to privacy. The genesis of such a stance may be seen in such cases as ***Griswold v. Connecticut,*** 381 U.S. 479; 14 L.Ed. 2d 510 (1965)(upholding the right to distribute and use prefertilization contraceptive devices); ***Loving v. Virginia,*** 388 U.S. 1; 18 L.Ed. 2d 1010 (1967)(holding a statute prohibiting interracial marriage violative of the Due Process Clause); ***Skinner v. Oklahoma,*** 316 U.S. 535; 86 L.Ed. 1655 (1942)(holding a sterilization law illegal and finding the right to procreation a "basic liberty").

In these and other cases the court has recognized a constitutionally protected right to privacy which is made applicable to the states through the 14th Amendment to the United States Constitution.

We believe the rationale of the case of ***Griswold v. Conn., supra,*** is applicable and may be extended to abortive action after conception and that the abortion statute interferes with the individual's private right to have or not to have children. Both the Pennsylvania and Connecticut statutes are at odds with current medical practice, both invade the intimate realm of marital privacy, both interfere with a married couple's freedom to control the number and spacing of offspring, and both are in conflict with a solution of one of the world's critical problems, the population explosion.

The United States District Court in *U. S. v. Vuitch*, 38 LW 2275 (1969)(cert. granted) and the Supreme Court of California in *People v. Belous, supra*, have each declared an abortion statute unconstitutional. Although these statutes were factually dissimilar to the statute here in question, the rationale we believe to be applicable in many respects.

The United States District Court for the Eastern District of Wisconsin has declared a state abortion statute unconstitutional as violating a pregnant woman's Ninth Amendment right of privacy: *Babbitz v. McCann*, 38 LW 2498, decided March 5, 1970. In this case a Wisconsin physician was charged with aborting an unquickened fetus.

We are convinced that the Pennsylvania abortion statute clearly impinges on constitutionally protected areas and without a doubt it is so broad, unlimited and indiscriminate that it fails to meet the present day tests for constitutionality.

Conclusion

We sincerely regret that the question of the constitutionality of this statute should reach this court in its present posture. The reprehensible actions of the defendant are in no way approved or condoned by the language contained herein or the court's decision. The only solace one can gather is the fact that this very statute created the undesirable situation involved in this case and that the legislature may hasten to adopt an abortion statute to meet the needs of present day society. Defendant's petition is therefore granted and the defendant ordered discharged.

BY THE COURT:

/s/ R. Paul Campbell

P.J.

Dated: July 23, 1970

AND NOW, to-wit: July 23, 1970, an exception is noted and bill sealed for the Commonwealth.

BY THE COURT:

/s/ R. Paul Campbell

P.J.

IN THE CIRCUIT COURT OF THE SEVENTH JUDICIAL CIRCUIT OF THE STATE OF SOUTH DAKOTA, WITHIN AND FOR PENNINGTON COUNTY

STATE OF SOUTH DAKOTA, Plaintiff,
-vs-
H. BENJAMIN MUNSON, Defendant.

MEMORANDUM DECISION

Apr. 6, 1970

The defendant herein, a licensed physician, is charged with abortion. By motion his counsel seeks dismissal of the information on the grounds that the abortion statute, under which he is being prosecuted, is unconstitutional.

According to reliable estimates, more than a million American women had abortions last year. Of these about 350,000 needed hospital care when they attempted to abort themselves, and more than 8,000 of these self-help cases died. ("Life" Magazine, Feb. 27, 1970.) Enforcement of the abortion laws has been chiefly against quacks and charlatans who have botched the job, and the woman lived to complain. Where death ensues, the prosecution has been for homicide. It is a rare case where a licensed physician has been prosecuted. In no instances has the woman been prosecuted, although the abortion laws are directed equally against the woman seeking an abortion.

With such mass disregard for the abortion law, reflecting a radical change in public attitude, it is in order to determine whether the exercise of the police power in prohibiting abortion is "sanctioned by usage, held by prevailing morality to be necessary to public welfare, or endangers the vital interests of society", criteria which over the years have been used to measure the right of the state to regulate personal and private conduct.

There has been a concerted drive in recent years to abolish or liberalize the abortion laws by statute or to challenge the constitutionality of such laws. Where the legislatures have acted some have liberalized the abortion laws and some have repealed them outright. Abortion is legal in most of Europe and in England. Most of the abortion laws were passed in the so-called "Victorian" era, a time when moral and religious fervor against anything regarded as sinful, resulted in many laws governing morals and personal conduct. The South Dakota Statute dates back to 1877. Most of these laws governing personal or private conduct, like the "blue laws" have either been repealed or have not been enforced. The laws prohibiting abortion represented a change from the common law which permitted

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abortion in the initial stages of pregnancy, before quickening of the fetus. In the 19th century when the abortion laws originated, all surgery was risky, and the needs of the frontier era was additional manpower. Now abortion is safer than childbirth, and the highly publicized public interest is in population control.

With the abortion laws on the books, only a small proportion of abortions are performed by licensed physicians, because most doctors are not willing to take the risk of prosecution and loss of their license, however small that may be. The rest are performed by people on a descending scale of competence down to the outright quacks and charlatans, or are performed by the woman herself in desperation where she does not have the funds to finance an illegal abortion. Are the interests of society being served by a law which exposed over a million women last year to such risks? Are the interests of society being served by women bearing unwanted children, subjected to the pressures of an emotionally and financially deprived existence? Are the interests of society being served by the population explosion we are now witnessing?

The abortion law has been held unconstitutional in California on the grounds that the words "necessary to preserve her life" in that state's abortion statute were unconstitutionally vague. People vs. Belous, 458 P(2) 194 (Cal. 1969). The District of Columbia law was invalidated on the same grounds where the language of the statute was "necessary for the preservation of the mother's life or health". U.S. vs. Vuitch, 38 Law Weekly 2275 (Nov. 10, 1969). The language of the South Dakota statute forbidding abortion, "unless the same is necessary to preserve her life" likewise presents the same basis for invalidity.

However, in the opinion of this court, the invalidity of the abortion law goes much deeper in that it interferes with private conduct without serving any vital interest of society. Indeed, it is a disservice to society under the conditions that have been outlined above. This court agrees without reservation with the recent opinion handed down by a three judge panel of the U. S. District Court for the Eastern District of Wisconsin, in the case of Babbitz vs. McCann, et al., #69-c-548, a copy of which was furnished to the court and opposing counsel by counsel for defendant.

Dr. Babbitz sought an injunction in federal district court against a prosecution in state court for performing an illegal abortion. The Wisconsin statute, set forth in detail in the opinion, provided a different penalty for abortion before quickening of the fetus than was imposed for abortion of the quickened fetus. Dr. Babbitz was charged with aborting a fetus before quickening. The court held that the statute under which he was charged was unconstitutional under the Ninth Amendment to the U. S. Constitution, the court concluding that "the State of Wisconsin may not by statute deprive a woman of her private decision whether to bear her unquickened

child", thus squarely facing the fundamental issues involved in the abortion laws.

This court adopts the reasoning of the court in the Babbitz case, under Section IV, which should be read in its entirety, since only portions will be quoted herein for emphasis.

Quoted with approval in Babbitz is the following excerpt from an article by former Supreme Court Justice Tom C. Clark in the Loyola University Law Review for April, 1969, in which Justice Clark concluded from a study of Griswold (striking down Connecticut statute forbidding use of contraceptives) and its predecessor cases:

> "The results of these decisions is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution."

Quoting further from the language of the court in Babbitz:

> "The defendants urge that the state's interest in protecting the embryo is a sufficient basis to sustain the statute. Upon a balancing of the relevant interest, we hold that a woman's right to refuse to carry an embryo during the early months of pregnancy may not be invaded by the state without a more compelling public necessity than is reflected in the statute in question. When measured against the claimed "rights" of an embryo of four months or less, we hold that the mother's right transcends that of such an embryo."

The court went on to find no compelling interest of society in the need to protect the mother's life, since abortion is presently less dangerous than childbirth, or in connection with the discouragement of non-marital sexual intercourse. In fact, most abortions are sought by married women and the laws do not purport to distinguish between married and unmarried women.

Accordingly, defendant's motion for dismissal of the information filed herein will be granted on the grounds that the abortion statute is an unconstitutional invasion of individual right, without a compelling interest in the State.

Counsel for the defendant may prepare an order accordingly.

By the Court:

Clarence P. Cooper, Circuit Judge

ATE v. KETCHUM
ch. Dist. Ct., Mar. 30, 1970 (Reid, J.)

OPINION - MARCH 30, 1970

This is the case of the PEOPLE OF THE STATE OF MICHIGAN vs. DR. JESSE KETCHUM AND JUDITH KETCHUM. The Defendants are charged with the crime of CONSPIRACY TO PERFORM AN ABORTION, contrary to M.S.A. 28.773 and M.S.A. 28.204.

At the beginning of the preliminary examination, Mr. John Bai attorney for the Defendants made an oral motion to dismiss the complaint and warrant on the grounds that the Michigan statute on abortion is unconstitutional because it is indefinite and uncertain and vague and therefore is in violation of the due process clause of the Fourteenth Amendment of the United States Constitution.

This Court recognizes that the issues raised in this proceeding have far reaching moral implications, theological implications, and medical implications. However, this Court will address itself solely to the legal issues raised in the motion.

Neither the Defendants' attorney nor the prosecuting attorney have cited to this Court any Michigan Supreme Court decision nor any Court of Appeals decision which have previously held this statute constitutional so therefore this Court is not bound by any prior decisions.

Due process of law requires a penal statute to use clear, explicit, and unambiguous terminology so that men of common intelligence may not differ as to its meaning and application. See Connelly vs. General Construction Company 269 U.S. 385 and Lanzetta vs. New Jersey 306 U.S. 468.

It is the applicable terminology of the Michigan abortion statute "unless the same shall have been necessary to preserve the life of such woman" clear, explicit, and unambiguous? The three key words "necessary," "preserve," and "life" taken individually by both judicial interpretation and dictionary definitions create uncertainty as to their individual meaning. The entire phrase in itself is susceptible to a variety of interpretations. This Court concludes that the terminology is not sufficiently clear, and explicit and does not satisfy the due process requirements without infringing on fundamental rights. See People vs. Belous, 80 Calif. Reporter 354, and The United States vs. Vuitch 38 LW 2275.

The Michigan statute provides for the standard of "any person... with intent thereby to procure the miscarriage of any such woman, unless the same shall have been necessary to preserve the life of said woman." The standard allows "any person" to decide who shall be born and who shall not be born. Certainly our country is established and maintained on the principle of the rule of law - a nation of laws and not of men. The standard "any

person" provides no procedural guidelines. Is not the decision as to who shall or shall not be born a decision in which society has an interest and not a decision to be made conclusively by "any person" without any guidelines to protect the basic rights of the parties involved?

Is there an infringement on the basic rights of the parties as protected under the Fourteenth Amendment? The Court believes that the parties involved include the woman, the unborn, and any person who is performing the abortion. The woman certainly has a right to life as opposed to the risks of death in childbirth. The woman has a right to privacy in matters relating to marriage, family and sex. See Griswold vs. Connecticut 381 U.S. 479. The real issue is whether the state has a compelling interest in the regulation of the right to privacy in matters of marriage, family, and sex. Currently accepted standards of medical practice negate the original compelling interest of the state because the need of the state to protect the woman's health when the abortion statute was originally enacted is no longer evident in light of scientific advancements.

The Court believes that the unborn person may be a person under the Constitution, and thereby shall not be deprived of life without due process of law. In Michigan the unborn child has the right to maintain a tort action, to sue for wrongful death of its parents after its birth. The right to property by means of inheritance. The right to a guardian ad litem in certain actions. Does not the unborn child have an absolute right to life - the right to be born? The Michigan statute as written does not provide for the taking of the life of the unborn person with due process of law.

In addition the statute as written infringes on the right of privacy in the physician-patient relationship, and may violate the patient's right to safe and adequate medical advice and treatment.

Thus this Court finds that the Michigan abortion statute as written is vague and indefinite in its terminology and possible applications as to constitute a denial of due process as protected by the Fourteenth Amendment of the United States Constitution and the Michigan Constitution of 1963 Art. a Sec. 17, and that it infringes on the basic rights of privacy of the woman, and the basic right of life of the unborn person, and infringes upon the right to privacy between physician and patient, without a sufficient state interest in abridging the right of privacy and the right of life. This Court declares the Michigan abortion statute unconstitutional as a denial of due process of law as protected by the Fourteenth Amendment of the U.S. Constitution and Art. 1 Sec. 17 of the Michigan Constitution. In view of the foregoing, this Court finds it unnecessary to consider the other arguments raised by defense counsel. The motion to dismiss the complaint and warrant is granted.

/s/ Clarence A. Reid, Jr.
Clarence A. Reid, Jr.
District Judge

Item No. 37

Order of the District Court, Second Judicial District, County of Ramsey, Denying Motion to Dismiss Indictment Against Appellant Jane E. Hodgson, M.D., Entered June 29, 1970

DISTRICT COURT
STATE OF MINNESOTA

COUNTY OF RAMSEY—SECOND JUDICIAL DISTRICT

File No. 23789

STATE OF MINNESOTA,

vs.

DR. JANE ELIZABETH HODGSON.

The defendant is accused by the grand jury of the County of Ramsey in an indictment returned on May 21, 1970, of the crime of abortion, in that she, the defendant, intentionally produced a miscarriage of one, Jane Doe, which said miscarriage was not necessary to preserve the life of the said Jane Doe nor the child with which she was pregnant. The defendant's first appearance in court was on May 26, 1970, at which time she appeared with her Counsel, Stewart R. Perry, and indicated to the Court that her appearance was a special appearance for the purpose of moving the Court for an order dismissing the indictment for the reason and upon the ground that the statute under which the indictment was returned was unconstitutional. The date of June 12, 1970, was then set as the time for hearing, and the requests to file briefs by both the State and the defendant were granted by the Court.

On June 12, 1970, the defendant, together with her Counsel, appeared before the Court to argue the above described motion. The County Attorney was represented by Mr. Paul Lindholm, Assistant Ramsey County Attorney. In the interim, briefs had been submitted by Mr. Perry and by Mr. Stephen C. DeCoster, Assistant Ramsey County Attorney.

Upon all of the files, records, and proceedings had and filed in said matter, briefs and arguments of Counsel, and after due consideration of the same,

IT IS ORDERED:

1. That the motion brought by defendant to dismiss the indictment returned against her in the above entitled matter be and the same hereby is denied.

2. That the request of the defendant to certify the above entitled matter to the Supreme Court of the State of Minnesota as important and doubtful be and the same hereby is denied.

3. That the defendant will appear before the Court on August 5, 1970, prepared to proceed with her arraignment.

(Signature Illegible)
Judge of the District Court

Dated June 29, 1970.

MEMORANDUM

The statute in question, MSA 617.18, was first enacted into law by the Minnesota legislature in the year 1873. As far as can be ascertained, this is the first constitu-

tional challenge of the statute, and the issues presented in this motion have not been decided in this jurisdiction. The Court has taken judicial notice of the materials cited in the briefs, but they are of such common understanding that they need not be elaborated on here in great detail.

The undisputed facts appear to be that Jane Doe, a married woman, of the age of 23 years, was a patient of the defendant, and on April 14, 1970, was diagnosed as being pregnant. From the medical history obtained, it was suspected that Jane Doe had contracted rubella during the first four weeks of her pregnancy, and that Jane Doe had come to the defendant because she suspected that she had rubella during that period of time. She was apprehensive about her condition, particularly her unborn child, because of her knowledge of the dangerous propensities of the disease. The history of rubella given by Jane Doe was confirmed by clinical observations and laboratory tests on two of her children who at that time had the disease, the examination and tests being performed by a pediatrician located in Minneapolis, Minnesota. Upon the tests having been made, together with examinations in connection therewith, the defendant was of the opinion that Jane Doe had rubella during the first four weeks of her pregnancy. Jane Doe and her husband were aware of the danger to the fetus because of the contraction of the disease and requested the defendant to perform an abortion. The defendant believed in her medical judgment that a therapeutic abortion was medically indicated, and she secured consultations from other members of her profession in the community and in other parts of the United States, resulting in the performance of the abortion in a hospital located in Ramsey County, Minnesota, on April 29, 1970. At that time Jane Doe was about 12

weeks pregnant, and the fetus was not viable or "quick." Before proceeding with the operation, the defendant brought a motion in the United States District Court, District of Minnesota, seeking, essentially, the same relief here presented. A three-judge court denied the motion of the defendant and indicated that she seek her relief in the courts of the State of Minnesota. Because of the lack of time, the defendant proceeded with the operation, rather than first seek her relief in the district courts of the State.

The issues presented cover three, general, broad areas. First, whether or not the State has the right to interfere with the private rights of an individual; two, if the State does have such right, it must have an overriding and compelling interest to justify any such interference with the private life of an individual; and, three, if there is an overriding State interest present today that justifies the existence of MSA 617.18, it is incumbent upon the State to establish such interest.

The Court will touch upon the constitutional issues raised by defendant as they pertain to these three general areas.

Defendant contends that the statute infringes upon the personal liberties of the individual concerned, in that it interferes with a woman's right of privacy in determining whether she will or will not, or should or should not, allow to grow within her body embryo which she does not wish to grow, and that in order for the State to interfere, there must be shown a reasonable basis, an overriding justification, a social purpose of such interference. Defendant further contends that at the time of its enactment, in the year 1873, there was an urgent and well-founded health basis for its passage. Any surgical intrusion into the body

was, at that time, highly dangerous. Infection was almost insured, and mortality was high. Defendant argues that today an abortion performed under proper circumstances is a reasonably safe procedure, even safer than normal childbirth. No doubt these considerations were in the mind of our legislators almost a century ago when the law was first enacted. However, the statute has been periodically reconsidered over the years, most recently at the last legislative session. Whatever the dangers of surgery the legislators might have had in mind during the early years of the history of this law, those considerations have seemed [*sic*] to have disappeared during recent years, and the law is still on the books. The reason for its existence is not because of dangers of surgery or performing an abortion, medically speaking. Some considerations for the continued existence of the law are hereinafter discussed.

Defendant places great emphasis on the fact that the State of Minnesota has never considered an embryo or fetus as a "human being." Defendant further contends that the statute in question denies the rights of the Father or the Mother of the aborted foetus to privacy in contravention of the Ninth and Fourteenth Amendments to the United States Constitution. There is authority to the effect that the unborn child, even before it becomes viable, is an entity which the legislature is empowered to protect. In early recorded history, the child in the Mother's womb was considered a part of its Mother. Reference is made to Roman law, see Justinian, Digest 25.4.1.1. But since that early date we have seen the development of scientific methods to such an extent that the ancient law has been reconsidered, and no longer is the fetus considered to be a plant, static in habit, and growing only in size. Through the marvels of closed-circuit x ray and television, scientific observations of

this little human being during his first weeks of existence have been made possible. Studies of mental growth have been made possible, during the first few weeks of the child's existence. Some studies have indicated that even in the limb bud stage, when the embryo is only four weeks old, there is evidence of behavior pattern: the heart beats. In two or more weeks, slow back and forth movements of the arms and legs appear. Before the 12th week of uterine life, the fingers flex in reflex graphs. From the studies of certain child psychologists, it has been disclosed that the process of mental development which characterizes a 10-year old child or the one-year old child also characterizes the embryo who might be only one month old. Hence, it would appear that the time has been reached when society must discard the theory advanced by the old Roman law, that a parent has an absolute dominion over his offspring, or a return to the ancient notion that a fetus is "part" of his Mother. The Minnesota legislature has made no such distinction, nor has it attempted to set out by law at what stage during pregnancy a child may be considered "quick" or "viable" nor has it at anytime determined at what stage during pregnancy the life of a child can or could be taken for any reason or means. Rather, the legislature has decreed that a miscarriage shall not be caused at anytime during pregnancy unless the same is effected as necessary to preserve the life of the Mother or the life of the child. The State has an interest in the continued existence of every life.

Defendant contends that unless the fetus in question is "quick" or viable, the unborn child has no legal rights in the State of Minnesota. The rights of the unborn child are specifically recognized by Minnesota law in its various

fields, such as: intestate succession; testate successions; trusts and uses; workmen's compensation; paternity and support; land registration; and future interests in real property. Various quotations make reference to "unborn child" and "posthumous child," "lives in being," "twenty-one years and nine months," but the law is entirely lacking with respect to definitions of "quick child" or "viable child." The Court recognizes there are rules and regulations promulgated by the State Department of Health pursuant to MSA 144.151 (4) to the effect that destroying a fetus is not considered a fetal death if aborted for any reason less than 20 weeks after conception. See Registration Manual for Birth and Fetal Death, State Board of Health (1965), Section 5, page 14. However, such regulations and publications are not considered decisive case law, nor are they controlling in the instant matter. Turning our attention to the field of tort law, the first time that the Minnesota State Supreme Court was called upon to pass upon the issue of the right of the heirs of an unborn child to recover in a wrongful death action was in 1949. See *Berkenes* vs. *Corniea* (1949) 229 Minn. 365, 38 N.W. (2) 838. It is noted that the Court, in part of its opinion, quoted Blackstone as follows:

> "The right of personal security consists in a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health and his reputation. Life is the immediate gift of God—a right inherent by nature in every individual; and it begins, in contemplation of law, as soon as an infant is able to stir in the Mother's womb."

The Court further quotes the case of *Bonbrest* vs. *Kots* (D.C.) 65 Fed. Supp. 138:

> "From the viewpoint of the civil law and the law of property, a child en bentra [*sic*] sa mere is not only regarded as a human being, but as much [*sic*] from the moment of conception—which it is in fact."

While it is true that the child in the Berkenes case had reached a viable state, it is noted that the Court made no distinction between a viable or nonviable child, that is, it does not appear that had the child not been viable, recovery would have been denied. There is substantial authority in other jurisdictions which allow recovery for prenatal injuries to nonviable, unborn children. There appears to be no holding or decision to the effect that would allow a shifting of standards in certain cases. There appears to be no reason to allow a distinction to be made, based upon age of the child within the womb. The dean of tort law, Professor Prosser, states at Section 56:

> "Certainly the infant may be no less injured, and all logic is in favor of ignoring the stage at which it occurs."

If the State legislature has seen fit to give the right of recovery to an unborn child or his heirs at various stages during pregnancy in the civil field, why should the child be abandoned at certain stages of pregnancy in the criminal field? If the unborn child at age 12 weeks within the womb has vested rights or the right in certain instances to recover, as hereinabove set forth and described, why should any person be deemed competent to judge that the child's twelve-week life may be taken because of the wishes of its Mother or Father, or because it is unwanted, or because of the possibility of its being deformed or handicapped because

of exposure to certain diseases during the early stages of life? Defendant would ask this Court to so legislate, contrary to what has taken place in the halls of our legislature for generations past. For the reasons hereinafter enumerated, this Court does not so choose to do.

Defendant alleges that the statute in question, MSA 617.18, today is based on the concept of "morality and decency" arising from religious laws in violation of the First Amendment to the United States Constitution. Defendant then points out that these individuals who rely on the position of morality and decency overlook the end results where abortion is not allowed. That is to say, they overlook those children who are being born with gross defects, who must live with them day by day, while those who would preach morality and decency are prompted by it only on occasions where their attention is drawn to what someone else is doing. Defendant further points out that these people overlook the institutions in Minnesota filled with mentally retarded people whose life is tragic, and that they overlook the daily pain that the parents and siblings of such children live, day by day. They further overlook the unwanted children in institutions and overlook the children who are periodically in hospitals with the "battered child syndrome." Defendant contends that it is immoral and indecent not to prevent this, and that it is immoral and indecent to force these institutions to exist.

Where the statute involved deals with conduct which the State has valid grounds to prohibit, that is, the taking of the life of an unborn child, the fact that its policies coincide with the views of certain religious groups is without constitutional significance. It is almost inevitable that any position taken by the State through its legislature on the

subject of abortion must correspond with the religious or moral views of some group or groups within the community. In passing such a law, the legislature did not intend that it establish a religion in contravention of the First and Fourteenth Amendments to the United States Constitution. This subject has been the concern of philosophers and theologians since recorded history has begun. The relationship between religion, morality, and law, perhaps, is difficult to clearly define. However, history teaches that they do overlap in the subjects of their concern. An historical study of the works of our legislative bodies will clearly indicate that many men in their respective roles as legislators were committed to the proposition that the ultimate source of law is from the ultimate Lawgiver Himself. Many have clearly indicated that a just law binds one's conscience, and if a law does not bind one in conscience, it should not be law. There are numerous references in the Old Testament as to the source of our law, among which are the Book of Proverbs, Chapter 8, and Exodus, Chapter 24. Five thousand years ago Hammurabi recognized a supernatural source of authority, and the same reference is also made to Solon, the great leader of freedom-loving Greeks. It seems that down through the centuries, men have further recognized the authority for law and would keep those convictions alive in various forms in the halls of their legislatures. Seven hundred years ago Henry Bracton wrote:

> "The king is under God and the law. When the king or dictator or the State is held above God and the law, liberty is never secure, and the rights of man are mere franchises subject to the whims of other men."

In more modern times these same thoughts might have inspired our great leaders, such as Thomas Jefferson, when he wrote:

> "We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness."

Society would reach a strange position in its history if the legislatures of the several states were forbidden from making illegal that which is also immoral according to one's religion, or, indeed, all religions, on the grounds of the establishment clause of the First Amendment. Under such restrictions society might then return to a state of chaos, even barbarianism. The Court recognizes the sincere views of the defendant in this field, and the remarks hereinabove set forth are not in criticism or ridicule of those views or beliefs. The Court is also cognizant of the views of the minority in our various communities who have views which coincide with those of the defendant in this area. However, to give effect to those views of the defendant or the minority, the Court again is called upon to legislate, and for the reasons hereinafter set forth, the Court will not undertake such a responsibility. The Court is also not unmindful of the anxiety of the Mother in this case. Having been exposed to German measles, she was apprehensive of the possibility of bearing or giving birth to a deformed or handicapped child. Instead of agreeing to take the child's life because of this possible exposure, might she not have at least better yielded to the argument of a segment of our society who would state:

> "Let the child run its normal period of gestation, and upon birth if it is found that the child will be a burden to its parents or society, then provisions may be taken for its destruction."

The very thought of such argument, perhaps, appears abhorrent to responsible members of our community, but wherein lies the difference? At what stage in the course of human existence, or development, can it be decreed that life should be taken because of the potential inability to perform as normal persons are expected? Society is increasingly concerned with those who have been blessed with healthy bodies, and prefer to serve themselves, and blame society, rather than serve society and honor themselves. Society has never forgotten, nor should it ever forget, that men and women with withered limbs and bodies became outstanding citizens, leaders in their communities, but above all, masters of themselves, while other healthy, vigorous, intelligent individuals, warped within the philosophy of excuse, for one reason or another, have become instruments of their own damnation.

Defendant asserts that the statute in question interferes with the right of privacy of women in violation of the Ninth Amendment to the United States Constitution. The Court agrees that legislation of this type might and can interfere with the right of privacy of certain individuals. This is true with many of the laws of today. A simple illustration concerns the matters of traffic regulations involving the use of a motor vehicle upon the highway. Many such rules and regulations or statutes interfere with the manner in which a person might desire to operate a motor vehicle, but in the protection of life and property, legislative safeguards have been provided, many of which interfere daily

with the rights of individuals. The same problem exists with many other types of legislation. For instance, there are still on the books laws against adultery and fornication, and how intoxicants and narcotics shall be used. These laws are considered by a substantial minority to be archaic in design, and no longer serve a useful purpose in a modern and developing society. However, it is clearly noted that our legislature over the years has not yielded to such arguments and philosophies. This Court does not agree that the statute in question relative to abortion is in violation of the Ninth Amendment of the Constitution of the United States.

Defendant asserts that the statute in question interferes with the right of a medical doctor to practice medicine in the highest standards thereof in violation of the Fourteenth Amendment to the United States Constitution. The Court agrees that the right to pursue one's profession is a constitutionally protected right within the concept of "liberty" and "property." However, it is also noted that medical opinion is divided as to the situations under which a therapeutic abortion is medically indicated. If the State cannot constitutionally regulate the exercise of that judgment, legislators and courts alike would be superfluous, supplanted by a wise elite of doctors. In a democratic society, trust cannot be placed with a body of experts to determine issues of life and death, however qualified, well-motivated, and devoted the experts may be.

Defendant further contends that the statute delegates to the physician the duty and risk of deciding whether the abortion is necessary to preserve the life of the Mother or child and thus violates the Fifth and Fourteenth Amendments to the United States Constitution. Defendant points out the difficulty here is that the doctor must decide

whether or not the abortion is necessary to preserve the life of the patient, and she apparently has difficulty interpreting the word "preserve." Defendant alleges that it is incumbent upon her to make the right decision as to whether or not an abortion is necessary to preserve the life and is thus placed in a conflict of interests; that is, caught between the decision to do the abortion and the fear that if something should go wrong, the matter would be brought to the attention of the police. Thereafter, the doctor must then justify her opinion at a trial. Hence, she jeopardizes her practice and runs the risk of prosecution whenever the decision is made to perform an abortion, where there is any question that medical opinion could differ as to whether or not the operation was necessary to preserve the life of the Mother or the child. This Court, upon examination of the statute, is not persuaded that the words are indefinite or vague. In the Court's opinion, the word "necessary" and the expression "to preserve the life of the Mother" are both reasonably comprehensible in their meaning. The United States Supreme Court has ruled that a criminal statute must be definite enough to acquaint those who are subject to it with the conduct which will render them liable to its penalties. See *Lanzetta* vs. *New Jersey*, 306 U.S. 451, 59 S. Ct. 618, 83 L. PB. [*sic*] 888 (1939). And also see *Connolly* [*sic*] vs. *General Construction Company*, 68 [*sic*] U.S. 385, 46 S. Ct. 126, 17 L. PB. [*sic*] 322 (1926). This Court is of the opinion that the statute sets forth with reasonable clarity and sufficient particularity the kind of conduct which will constitute a violation. It is interesting to note that the defendant challenges the words "necessary to preserve her life" as being vague. The Court is not unmindful that the dedicated medical profes-

sion assumes this responsibility without hesitation almost daily in its various practices. It is deeply interesting to note that the statute in question has been law for a period of almost 100 years, and until the present time no one has challenged the provisions of the statute as being indefinite or vague. The Court cannot agree with the defendant that the statute involves a delegation of legislative responsibility. The legislature has simply set a certain standard, and that is, that no abortion shall be carried out unless necessary to preserve the life of the Mother, and then requires that the individual condition his or or her conduct on a respect for the standard as set. It would appear that the requirements laid out are no more burdensome than those which are established by any criminal law. Such a requirement placed upon the individual is, in no sense, a delegation of legislative responsibility.

The State contends that there are valid policy reasons underlying the statute in question; therefore, the doctrine of separation of legislative and judicial functions and the long-settled judicial rule of reticence in substituting the Court's own notions of legislative wisdom for that of a democractically elected legislature dictate that the challenged statute be sustained. The question of the validity of anti-abortion legislation is not the only issue of importance here. The issue of separation of legislative and judicial functions is as well involved. Even though a court may go so far as to opine that a particular statute in question be unwise, silly, or even asinine, if it has been demonstrated that the statute in question is reasonably tailored to the protection of societal interests with respect to which the legislature is entitled to act, then such act should not be torn down by a court who differs in opinion, philosophically or socially. This does not mean that there are

not policy grounds for a change in abortion laws which were ably stated in defendant's brief and exhibits. What it does mean is that these arguments are more properly addressed to the legislature of this State, and ultimately to its people. This Court is asked to balance the rights of an unborn child against the rights of the Mother, contrary to what the legislature has so consistently stated. Whose rights shall transcend? Who shall balance the relevant interests? This Court is of the opinion that the problem of balancing is more properly the function of the legislature and of the people of the respective states. In the case of Commonwealth vs. Brunell [*sic*], not yet reported, the Court stated:

> "The subject of abortion has become one of the most controversial social and legal issues of our contemporary society. Reasonable arguments have been advanced both in favor of and against abortion. But when a question is fairly debatable, the courts cannot substitute their judgment on it for that of the legislature." Citing *Druzik* vs. *Board of Health of Aberhill,* 324 Mass. 129. "It is only when a legislative determination cannot be supported upon any rational basis of fact that a court can strike it down. If the law on abortion is not as responsive to felt needs as the people believe contemporary life demands, the remedy rests with a democratically elected legislature and not with the court."

Defendant requests the Court that the statute in question be found constitutional but to then certify the matter to the Supreme Court of the State of Minnesota pursuant to MSA 632.10 for a determination of the constitutionality of

the statute prior to trial. This would obviate the necessity of raising the defense that she might have, relative to a verdict of innocence or guilt, and would at the same time give statewide effect to the ruling on constitutionality. If the Court in the local instance should find the statute unconstitutional, that ends the matter, and there would be no statewide effect of that local decision. Defendant also points out to the Court that a conviction, including a plea of guilty, would be most serious and would place her professional standing in jeopardy. She feels that if the matter should go to trial at the local level without a Supreme Court determination as to constitutionality, then her whole plan becomes moot inasmuch as she will be put to the task of defending herself against the charge brought by the grand jury, and if she is successful at the trial on the merits, again, the matter would not have any statewide impact.

In the light of the foregoing observations and conclusions drawn by the Court, it is obvious that the matter cannot be certified to the Supreme Court of the State of Minnesota, as important and doubtful. The Court believes that the issue or matter is important, but in this Court's opinion the constitutionality of the act in question is not in doubt. Under the circumstances, the Court has no alternative but to order that this matter proceed pursuant to the ordinary rules and processes of our criminal procedures.

The Court is not unmindful of the standing of the defendant in her community, her reputation as a citizen and as a dedicated physician and surgeon, and the Court is not unmindful of the serious position that she is in pursuant to the charge brought against her. However, it is she who chose to violate the law, and she certainly must have been cognizant of the consequences that might follow. In the

opinion of some of her professional colleagues as well as many in this community she will be considered as a very courageous and dedicated person in choosing the course of conduct that she did. Conversely, there will be other members of her profession and members of our community who do not and will not agree with her. Unfortunately, this Court cannot be a part of any plan or procedure other than those duly provided by law. No exception can be made in any case, even though a court might be in sympathy with the actions taken by the defendant.

The regular and ordinary criminal procedure processes established by law and within this Court's responsibility, require that the defendant be ordered to appear for her arraignment, which has been set for August 5th, next. Defendant will then have to decide whether to bring the matter on for trial relative to the issue of her innocence or guilt of the crime as charged or to enter a plea of guilty, and rest her future standing in the hope that the Supreme Court of the State will take a contrary view to that expressed herein.

HACKEY, *J.*

Item No. 38

Commonwealth of Massachusetts

Middlesex, ss.

Superior Court
No. 83879

COMMONWEALTH

v.

PIERRE VICTOR BRUNELLE

DECISION ON DEFENDANT'S SUBSTITUTE MOTION TO DISMISS

The defendant has been indicted for an alleged violation of G. L. c. 272, sec. 19, the so-called abortion statute. The indictment charges that he "with intent to procure the miscarriage of Linda A. Phillips, did unlawfully use a certain instrument upon the body of said Linda A. Phillips."

After pleading not guilty, the defendant filed a substitute motion to dismiss the indictment on the ground that the statute he is charged with violating is unconstitutional. At the hearing of this motion, evidence was received from experts in the fields of medicine and psychiatry. The motion sets out ten grounds on which the statute is claimed to be unconstitutional. Some of these grounds will be discussed separately; others will be grouped together.

I.

The Claim that the Statute violates the First Amendment and the Fourteenth Amendment in that it establishes a Religious Position Peculiar to one Religion.

The defendant contends, in substance, that the statute effects an establishment of religion because it enacts into law the doctrine of the Roman Catholic Church on the subject of abortion. Quite properly, the defendant does not contend that the original abortion statute enacted in 1845 (St. 1845, c. 27) was passed as a result of pressure by the Catholic Church or for the purpose of giving a Catholic moral position the force of law. But the defendant does contend that the effect of retaining in force G. L. c. 272, sec. 19 "is to enact into law theological tenets of some organized religions in this most important area of human life." (Defendant's Brief, p. 18). Two answers may be given to this argument.

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First, the Massachusetts statute, as construed by the Supreme Judicial Court, is not in accord with the Catholic view on abortion. See Code of Cannon Law, 2350, sec. 1; Tinnelly, Abortion and the Penal Law, 5 Catholic Lawyer 187, 190. Second, there in no factual basis for any claim that the present purpose of the statute is to give legal effect to any particular religious viewpoint or that in its operation the statute does have that effect. It is almost inevitable that any position taken by the state through its legislature on the subject of abortion must correspond with the religious or moral views of some group within the community. The fact that a law coincides with a religious view does not render that law an unconstitutional establishment of religion. For example, the fact that Sunday is a day of particular significance for the dominant Christian sects does not bar the state from achieving the secular goal of requiring the observance of Sunday as a day of rest. *McGowan v. Maryland,* 366 U.S. 420; *Gallagher v. Crown Kosher Super Market,* 366 U.S. 617. If the state decides that it is in the public interest to restrict abortions to situations involving the life or health of pregnant women, it is not forbidden to do so because that view corresponds with the moral views of a majority or of a minority in the community.

The defendant's argument that the abortion statute violates the free exercise clause of the first amendment is without merit for, while the freedom to hold religious beliefs is absolute, the freedom to act upon those beliefs may be limited where there is a substantial state interest. *Braunfeld v. Brown,* 366 U.S. 599. The interest of the state in protecting what it considers to be human life would appear to be at least as substantial as any interest in maintaining Sunday as a day of rest. See *Raleigh Pitkin-Paul Morgan Mem. Hosp. v. Anderson,* 42 N.J. 421, 201A.2d 537, cert. den. 377 U.S. 985 (1964).

II.

The Claim that the Statute Violates the Due Process Clause of the Fourteenth Amendment and the Massachusetts Constitution, Part 2, C. I, Article IV, in that it is Arbitrary, Irrational, and Not Suited to Achieve any Valid Legislative End.

It is quite probable that the original Massachusetts statute on abortion when enacted in 1845 had as its primary purpose the protection of the health of the mother. At that time an abortion was attended by grave risk to the life and health of the pregnant woman. Due to advances in the last century in medical science and techniques,

an abortion today, carried out by a competent physician in an accredited hospital, involves no more risk to the mother than continued pregnancy and childbirth. It is still true, however, that abortions performed by non-medical persons involve serious risks to the life and health of the woman.

The defendant argues that since there is little danger, comparatively speaking, to the health of the mother in the case of an abortion performed by a properly trained physician, there is no valid state interest served by proscribing an abortion by such a physician even though the abortion may not be necessary to preserve the woman's life or health. In other words, it is argued, the state may not validly deprive a pregnant woman of the right to an abortion requested by her when the only ground of such proscription is the moral one of protecting the fetus.

At the outset, it may be doubted whether the defendant has standing to raise the issue of the constitutional right of a woman not to bear children. It does not appear that the defendant is a duly licensed physician. On a motion to dismiss I cannot assume that he is or is not so licensed. It is rather obvious that the state has the power to forbid persons who are unlicensed physicians to perform abortions. The risk to the health of the mother from allowing unlicensed persons to practice medicine would alone be an adequate ground for the state intervening.

Assuming, however, that the defendant does have standing to raise these issues, I shall deal with them on their merits. There can be no doubt that the abortion statute, although broadly construed by the Supreme Judicial Court, does restrict the liberty of action of a pregnant woman who seeks an abortion solely for personal or social or economic reasons. The question is whether this restraint on her liberty is justified by any compelling state interest. The Commonwealth asserts that the state has a justifiable and overriding interest in protecting the embryo or fetus and that the desire of the woman must be subordinated to this public interest. The basic question posed is whether the legislature may validly regulate the extermination of human life at an early state of its development.

The evidence before me clearly establishes that the product of human conception -- whether it be in the stage of zygote, embryo, or fetus -- may properly be classified as human life. It is not potential human life, but actual human life. The zygote contains within itself the genetic package that will control its development during

its life in the womb and in the world. It is uniquely different from any other part of its mother's body. It is a human being in and of itself in the sense that it is an individual entity human in origin, human in its characteristics, and human in its destiny. Whether it is proper to describe this entity as a human person is a matter of disagreement. The law has not, at least as yet, given full recognition as a juristic person to the embryo or fetus. To a limited extent the fetus has been granted rights as a person, contingent on its birth. *Torigian v. Watertown News Co. Inc.*, 352 Mass. 446; *Meyes v. Construction Service, Inc.*, 340 Mass. 633. Cf. *Dietrich v. Northampton*, 138 Mass. 14. It is difficult to accept the view that because the state has not fully recognized the unborn child as a legal person it lacks power to extend any protection to the fetus or embryo. Although there is some authority to this effect (*People v. Belous*, 80 Cal. Rptr. 354, 458 P.2d 194; *United States v. Vuitch*, 305 F. Supp. 1032), it is of questionable weight here in view of the different statutes under consideration in those cases. Protection of life has traditionally been one of the first duties owed by a state to its people. To say that the state has no interest in life prior to birth except as the mother may choose to permit the state to have an interest is to accept a proposition that contradicts the action of every state legislature. In this area of competing values, if the legislature sees fit to make a choice in favor of life, I find nothing in the federal or state constitution that says that such a choice is forbidden.

III.

The Claim that the Statute Infringes the Right of Privacy of a Pregnant Woman Desiring an Abortion.

The defendant contends that G. L. c. 272, sec. 19, not only invalidly restrains the liberty of a pregnant woman to bear or not bear a child, but that it also invades her constitutionally protected right of privacy. It is argued that her right to plan her reproductive life and her family as she sees fit is within a protected zone of privacy under the first, ninth, and fourteenth amendments of the constitution. Again, there is a question of the defendant's right to raise such an issue in the absence, at least, of evidence of his status as a duly licensed physician. But laying aside this objection, I rule that the claim is without substantial merit.

A nebulous concept of right of marital privacy found recognition in *Griswold v. Connecticut*, 381 U.S. 479. In that case the Supreme Court struck down the Connecticut

contraception statute. The defendant argues that, analogously, the abortion statute as applied to married women invades a constitutionally protected right of a married woman to the control of her reproductive faculties. Some support for this view can be found in the two abortion cases previously cited, *People v. Belous*, supra, and *United States v. Vuitch*, supra. However, there is a distinction between the state's attempted regulation of the marital use of contraceptives and the regulation of abortion. The state's interest in the protection of embryonic and fetal life, absent in the *Griswold* situation, is crucial to the abortion issue.

It may be added that it does not appear whether the woman named in this indictment as the subject of the abortion was married or unmarried.

IV.

The Argument that the Statute is Void on its Face because of its Vagueness.

The Statute in full (G. L. c. 272, sec. 19) reads as follows:

"Whoever, with the intent to procure the miscarriage of a woman, unlawfully administers to her, or advises or prescribes for her, or causes any poison, drug, medicine or other noxious thing to be taken by her or, with the like intent, unlawfully uses any insturment or other means whatever, or with like intent, aids or assists therein, shall, if she dies in consequence thereof, be punished by imprisonment in the state prison for not less than five nor more than twenty years; and, if she does not die in consequence thereof, by imprisonment in the state prison for not more than seven years and by a fine of not more than two thousand dollars."

It is an established constitutional principle that "a statute which either forbids or requires the doing of an act in terms so vague that men of common intelligence must necessarily guess at its meaning and differ as to its application violates the first essential of due process ..." *Connelly v. Central Construction Co.*, 269 U.S. 385, 391; *Lansetta v. New Jersey*, 306 U.S. 451. The broad language of the Massachusetts statute, if taken literally and without clarifying judicial construction, might well be open to the charge of vagueness. But the statute has been construed by the Supreme Judicial Court and has been given a specific content that provides adequate guidelines to physicians. Decisions of that court have held that a duly licensed physician may lawfully procure the abortion of a patient if he acts in good faith and in an honest be-

lief that it is necessary for the preservation of her life or to prevent serious impairment of her health, mental or physical, and if his judgment corresponds with the general opinion of physicians in the community in which he practices. *Commonwealth v. Wheeler,* 315 Mass. 394; *Commonwealth v. Nason,* 252 Mass. 545; *Commonwealth v. Brunelle,* 341 Mass. 675.

Moreover, the question is not an open one in this Commonwealth. In *Kudish v. Board of Registration,* Mass. Adv. Sh. (1969) 883 it was held that the statute was not void for vagueness. Two courts have recently utilized the void-for-vagueness principle to strike down abortion statutes which contained an exception permitting abortion when necessary to preserve the life of the mother in one case, and when necessary to preserve the life or health of the mother in the other case. *People v. Belous,* supra; *United States v. Vuitch,* supra. But in neither of these cases was the statute so construed as to give decisive weight to the good-faith judgment of the physician.

The statute, as construed by the Supreme Judicial Court, is no more vague than many traditional concepts of the law such as murder, manslaughter, criminal negligence, and the right of self-defense.

V.

The Claim that the Statute Infringes on the Constitutional Right of Free Speech and on the Freedom of Physicians to Practice their Profession.

The defendant contends that the abortion statute violates his constitutional right of free speech in that it makes criminal the mere conveying of information to a person, knowing that the person can utilize the information to procure an abortion. Also, the defendant claims that the statute unduly interferes with the freedom of the physician to practice his profession, according to his best medical knowledge.

The statute as applied to the defendant raises no question of freedom of speech or the rights of physicians to practice their profession. He is not charged with advising or prescribing an abortion. He is charged with unlawfully using an instrument on the body of a woman with intent to procure an abortion. Hypothetically, it is possible to imagine a situation in which a serious question of first-amendment rights may arise in the application of the statute, but this defendant lacks standing to raise it. Moreover, since it does not appear that he is a licensed physician, he is not entitled to come forward as the champion of the medical profession. As to the power of the state to regulate that profession, see *Kudish v. Board of Registration,* supra; *Lawrence v. Board of Registration,* 239 Mass. 424.

Some miscellaneous arguments advanced by the defendant do not require detailed treatment. For example, the defendant contends that the statute is an invidious discrimination against the poor in violation of the Equal Protection Clause of the fourteenth amendment in that the poor cannot afford to hire physicians or psychiatrists who can legally prescribe therapeutic abortion. The stature is nondiscriminatory on its face. To the extent that it may be discriminatory in operation, the cause is economic, not legal. If a remedy is needed, it lies with the medical profession and the legislature, not with the courts.

The defendant also complains that the statute subjects those who violate it to cruel and unusual punishment. This contention is without merit. A legislature is not required to fix or impose any particular penalty for a crime. The penalties set out in the statute cannot be said to be wholly disproportionate to the gravity of the evil which the legislature could deem to result from illegal abortions. In any case, the defendant has neither been convicted or sentenced. It will be time enough to consider the issue if and when it becomes relevant. See *Commonwealth v. Baird*, Mass. Adv. Sh. (1969) 727, 247 N.E. 2d 574; *Commonwealth v. Leis*, Mass. Adv. Sh. (1969) 97, 243 N.E. 2d 898.

CONCLUSION

The subject of abortion has become one of the most controversial social and legal issues of our contemporary society. Reasonable arguments have been advanced both in favor of and against abortion. But when a question is fairly debatable, courts cannot substitute their judgment on it for that of the legislature. ***Drusik v. Board of Health of Haverhill***, 324 Mass. 120. It is only when a legislative discrimination cannot be supported upon any rational basis of fact that a court can strike it down. If the law on abortion is not as responsive to felt needs as the people believe contemporary life demands, the remedy rests with a democratically elected legislature and not with the courts.

The defendant's substitute motion to dismiss is denied.

ENTERED:

Cornelius J. Moynihan
Associate Justice

III.

LEGAL COMMENTARY

RELIGION, MORALITY, AND ABORTION: A CONSTITUTIONAL APPRAISAL

*by Mr. Justice Tom C. Clark**

Thought without action is an abortion;
action without thought is folly.[1]

Our society is currently in the midst of a sexual revolution which has cast the problem of abortion into the forefront of religious, medical, and legal thought. In my day at the bar all discussion of abortion was taboo. For more than sixty years the American Medical Association had a negative policy respecting abortion. The A.M.A. often sought the prosecution of any doctor who engaged in the practice of abortion, regardless of the merits of the individual situation. Society's general attitude toward abortion was such that the patient was ostracised and the doctor was disgraced. As in so many other facets of its moral code, however, society was hypocritical in its behavior. Despite the public pronouncements against its practice, abortions increased, especially among married women, and judicial action against the participants decreased in proportion.[2]

Some social commentators argue that Freud prepared the way for the Kinsey Report, which in turn set the stage for the sexual permissiveness that Reinhold Niebuhr called "moral anarchism."[3] This permeating permissiveness engendered a need for more efficient birth control methods, such as "the pill," and precipitated the doom of the old hypocrisy.

The law, lagging behind as usual, began to emerge from its quagmire and rid itself of the archaic restraints on abortion. In 1962 the American Law Institute proposed an affirmative policy declaring that the termination of pregnancy is justified whenever (1) its continuance would gravely impair the physical or mental health of the mother, (2) the child would be born with grave physical or mental defects, or

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* Associate Justice, Supreme Court of United States (Retired), 1949-67.

1 *The Wisdom of Nehru*, 34 WISDOM 62 (The Wisdom of India ed. 1960).

2 R. THOMLINSON, POPULATION DYNAMICS 198-99 (1965).

3 Niebuhr, *Kinsey and the Moral Problem of Man's Sexual Life*, in AN ANALYSIS OF THE KINSEY REPORTS ON SEXUAL BEHAVIOR IN THE HUMAN MALE AND FEMALE 62 (D. Geddes ed. 1954).

(3) the pregnancy was the result of rape, incest, or other felonious intercourse.[4]

Within five years of this proposal, the A.M.A. reversed its negative policy and adopted the A.L.I. proposal with only a few nuances.[5] During the next two years, five states liberalized their abortion laws and adopted the A.L.I. proposal.[6]

A further liberalization occurred in Great Britain with the adoption of the 1967 Abortion Act, which permits doctors to consider the mother's "actual or forseeable environment" in deciding whether an abortion is necessary.[7] The American College of Obstetricians and Gynecologists (A.C.O.G.) recently advocated enactment of similar legislation in this country.[8] While the permissiveness of the legislation would contradict existing laws in all states, the A.C.O.G. made it clear that it does not counsel disobedience to the law. It merely recommended liberalization and repeal of inconsistent laws. It did not, however, advocate the legalization of abortion for any unwanted pregnancy or as a population control device.

Various religious, medical, psychological, and legal organizations have been striving to reach some level of accord on the issues involved in promulgating a realistic and acceptable policy toward abortion. Emphasis on this topic is the result of many factors, including the chaotic state of thinking that prevails among the professions and the public, and the medical, emotional, and legal consequences which aborticide has on today's society.

The Christian Medical Society's symposium on controlling human reproduction provides a recent illustration of the disagreement that exists among professionals concerning abortion. Distinguished clerics, psychologists, doctors, and lawyers sought to determine what course of action should be followed. They were unable to answer many important questions, such as: Is the control of human reproduction against the will and spirit of God? At what stage of the gestation period does the fetus acquire human status? What are the constitutional limitations upon the State in prohibiting or limiting the control of

[4] MODEL PENAL CODE § 230.3(2) (Proposed Official Draft, 1962).

[5] Committee on Human Reproduction, *AMA Policy on Therapeutic Abortion*, 201 J.A.M.A. 544 (Aug., 1967).

[6] CAL. HEALTH & SAFETY CODE §§ 25950-54 (West Supp. 1967); COLO. REV. STATS. 40-2-50 (Perm. Cumm. Supp. 1968); GA. CODE ANN. § 26-1202 (effective July 1, 1969); LAWS OF MD. ch. 470 (Supp. 1968); N.C. GEN. STAT. § 14-45.1 (Supp. 1967).

[7] Abortion Act 1967, c. 87, at 2033.

[8] *Just How Great Are the Risks of The Pill?*, MEDICAL WORLD NEWS, May 24, 1968, at 23.

reproduction? I ask myself, "Heaven knows; who can tell? Who shall decide when experts disagree?" These and many other questions must be answered if we are to attain our goal of an aborticide policy that is responsive to modern society's needs and desires.[9]

In a recent conference the Association for the Study of Abortion experienced far greater success in agreeing on an aborticide policy. Dr. Robert Hall, President of the Association, said that the conference was designed to "relate what we know about abortion, and to determine what, if any, extent our attitude toward abortion should change with changing times. . . ."[10] The conference reviewed numerous reports dealing with present abortion laws. One of these reports concerned the effect of California's recently liberalized abortion law. It was noted that while the number of therapeutic abortions performed in California hospitals this year will rise from six hundred to about four thousand, there will continue to be some one hundred thousand illegal abortions performed in that state, because doctors are concerned about risking a prison sentence for an incorrect interpretation of ambiguous provisions of the liberalized law.[11] The conference was also informed that psychiatrists and physicians in various states were referring patients to doctors in states which have more liberal abortion laws. This practice renders the availability of legal abortion dependent upon the woman's ability to reach such states.[12] Many doctors admitted privately that they and most of their non-Catholic colleagues perform several illegal abortions each month. Kenneth R. Whittemere reported that his recent interviews revealed that in one small Southern city, women had a choice between "a chiropractor, an antique dealer, a mid-wife, a mechanic and a doctor dissatisfied with his profession to perform the operation."[13]

The Association reached an almost unanimous conclusion that all abortion laws should be abolished and that the right of childbirth should

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[9] The theological and medical scholars did agree on *A Protestant Affirmation*. It did not undertake to answer any of the questions posed in the text. In substance, the consensus concluded that as to abortion "each case should be considered individually, taking into account the various factors involved and using Christian principles of ethics." It suggested that suitable cases for abortion would fall within the scope of the A.C.O.G. statement, but not including abortion for convenience only or on demand. *See* CHRISTIAN MED. SOC'Y J. (Nov.-Dec., 1968).

[10] Meeting of the Ass'n for the Study of Abortion, Hot Springs, Va., Nov. 18, 1968, reported in N.Y. Times, Nov. 24, 1968, at 77, col. 1.

[11] *Id.*

[12] *Id.*

[13] *Id.*

be left to each woman acting on the advice of her doctor. This would have the effect of removing the issue from the hands of the legislatures and the courts, which are virtually helpless to decide an ethical question as controversial and far-reaching as abortion.[14] Whether or not we agree with the Association's recommendations, it is readily apparent at this point that a uniform scheme concerning abortion is highly desirous.

Throughout history religious belief has wielded a vital influence on society's attitude regarding abortion. The religious issues involved are perhaps the most frequently debated aspects of abortion. At the center of the ecclesiastical debate is the concept of "ensoulment" or "personhood," *i.e.*, the time at which the fetus becomes a human organism. The Reverend Joseph F. Donseel of Fordham University admitted that no one can determine with certainty the exact moment at which "ensoulment" occurs, but we must deal with the moral problems of aborting a fetus even if it has not taken place.[15] Many Roman Catholics believe that the soul is a gift of God given at conception. This leads to the conclusion that aborting a pregnancy at any time amounts to the taking of a human life and is therefore against the will of God. Others, including some Catholics, believe that abortion should be legal until the baby is viable, *i.e.*, able to support itself outside the womb. In balancing the evils, the latter conclude that the evil of destroying the fetus is outweighed by the social evils accompanying forced pregnancy and childbirth.[16]

Most civilizations of antiquity prohibited the practice of abortion. Ancient Judaism prohibited birth control except in times of famine.[17] Assyrian law imposed the death penalty upon any person participating in an abortion, including the procurer.[18] Even pagan writers described abortion as an evil act prohibited by law.[19]

The New Testament is devoid of pronouncements bearing directly on the issue of birth control or abortion. The Old Testament, however, does not condemn abortion as a capital offense since the fetus was not regarded as possessing a soul within the Sixth Commandment

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[14] *Id.*

[15] *Id.*

[16] *Id.*

[17] For studies in this area see L. EPSTEIN, MARRIAGE LAWS IN THE BIBLE AND THE TALMUD (1942); L. EPSTEIN, SEX LAWS AND CUSTOMS IN JUDAISM (1948).

[18] H. SAGGS, THE GREATNESS THAT WAS BABYLON 215 (1962).

[19] PAULY'S REAL-ENCYCLOPÄDIE DER CLASSISCHEN ALTERTUMSWISSENSCHAFT (Wissowa ed. 1962).

proscription.[20] It does declare, however, that conception is a gift of God which can be withdrawn at His will.[21] Many theologians today argue that man must not destroy what God has created and that aborting a pregnancy destroys the gift of human life.[22]

The medical profession is far from agreeing on the time at which the fetus becomes a human life. Some physicians argue that abortion should be permitted with impunity at any time up to the sixth month of pregnancy since prior to that time the fetus is no more than a growing plant.[23] On the other hand, many eminent physicians believe that the fertilized ovum has human life from the time of conception.[24] In support of this argument they refer to the International Code of Medical Ethics, which states that a physician will maintain the utmost respect for human life, from the time of its conception. A third view is that the decision to terminate a pregnancy must be made according to the circumstances of the particular case. Among the factors to be considered are the duration of the pregnancy, the physical and mental health of the mother, and the risk of serious fetal abnormality. This places the burden of decision upon the doctor and renders the selection of the physician a governing factor in securing permission to perform a therapeutic abortion.[25]

Sociologists have found themselves in a similar quandary over the issue. Some of these social philosophers argue that man is not merely a chemical machine and that he possesses a soul from the earliest stages of fetal development. Therefore the fetus cannot be destroyed with impunity. The control of human reproduction, according to this view, should concentrate on the prevention of conception rather than on abortion.[26] Other sociologists believe that there is no conclusive evidence or persuasive argument that the fetus is human.[27] Indeed,

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[20] *Exodus* 3:21.

[21] *Genesis* 1:28, 4:1, 11:30; *Ruth* 4:13.

[22] Montgomery, *How to Decide the Birth Control Question*, CHRISTIANITY TODAY, March 4, 1966, at 10.

[23] Stern, *The Issue of Legalized Abortion*, 88 CAN. MED. ASS'N J. 899 (1963); J. FLETCHER, MORALS AND MEDICINE 152 (1967); address by E. Bidinton, Symposium of Christian Medical Society, Aug., 1968.

[24] *See generally* PHILOSOPHY AND ETHICS IN MEDICINE (M. Gelfand ed. 1968).

[25] *See Therapeutic Abortion*, 98 CAN. MED. ASS'N J. 512 (1968).

[26] R. ETTINGER, THE PROSPECT OF IMMORALITY 132 (1962). *But see* Hudeeczek, *De Tempore Animatianis Foetus Humanis Secundum Embroyologiam Hodiernam*, in XXIX ANGELICUM 162-81 (1952). *See also Cyronics and Orthodoxy*, XII CHRISTIANITY TODAY 816 (1968).

[27] Address by John Scanzoni, Ph.D., Assoc. Prof. of Sociology, Indiana Univ., Nat'l Convention of Christian Medical Society, Aug., 1968.

it cannot interact with other human beings. Therefore, there is no proof of life in the sense that the law contemplates proof of fact.

The moving spirit of the times also raises moral issues that divide the disciplines within themselves. A group of one hundred psychiatrists were questioned on the morality of abortion.[28] Twenty-four agreed that abortion should be available upon demand at an appropriate stage of pregnancy. Fifty-six, however, would require consideration of all of the medical and social factors involved in each case before deciding whether to terminate the pregnancy. Sixteen of those questioned would abort only when actual or threatened maternal disaster was present. Only four expressed other views. While this indicates a vast departure from the Christian concept, it does reveal residuals of morality affecting the opinions of over two-thirds of the group. In other words, over two-thirds of the group would not abort a pregnancy solely on demand.

Despite the fact that religious belief continues to permeate our attitude toward abortion, most people today agree with Justice Holmes that "moral predilections must not be allowed to influence our minds in settling legal distinctions."[29] This is illustrated by the fact that the present change in attitude toward abortion has developed while the need for abortion has diminished as a technique to save the life or health of the mother or to prevent fetal deformities. Despite the medical developments, the demand for abortions has increased astronomically.[30] This indicates a definite change in social mores, which is undoubtedly the result of increased knowledge and use of abortion. This attitude of permissiveness is replacing the hypocrisy that prevailed in the last generation.

A major contributing factor to this change in attitude has been the growing antagonism toward the double standard which permits those with social status and financial ability to obtain abortions, while those in the lower social and economic classes are denied this opportunity. We are in the midst of a worldwide movement to make "the pill" and abortion available in the slums as well as on Fifth Avenue. The statistics illustrate the disparity between the affluent and the nonaffluent. Three counties surrounding San Francisco are relatively affluent. These counties account for sixteen per cent of the live births and fifty

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28 Howells, *Legalizing Abortion*, 1 LANCET 728 (1967).

29 O. W. HOLMES, THE COMMON LAW (1881).

30 *The Cost of Life*, 60 PROCEEDINGS OF ROYAL SOC'Y OF MEDICINE 1235 (1962); Cogan, *A Medical Social Worker Looks at the New Abortion Law*, 2 BRITISH MED. J. 235 (1968).

per cent of the abortions in California. The less affluent Los Angeles County with its widespread slum areas accounts for sixty per cent of the live births and twenty-three per cent of the abortions in California.[31] These facts demonstrate quite clearly that the affluent areas account for a number of abortions disproportionate to their population density.

The increasing number of abortions subjects physicians to increased dangers of liability for incorrectly interpreting a statute. It appears that doctors face an uncertain fate when performing an abortion. This uncertainty will continue unless the legislatures or courts provide relief from liability. Very few states, if any, will repeal all abortion laws as the Association for the Study of Abortion has recommended. Some states, however, may liberalize their laws in accordance with the A.L.I. suggestion, but we have already seen that in states such as California this is an inadequate remedy in many respects. If the medical profession is to be accorded complete protection, it will have to come through the judicial system.

The Supreme Court of the United States has gone far—some critics contend too far—in permitting individual action in the areas of the Bill of Rights. It has not, however, dealt directly with the problem under discussion, nor do the decided cases cast much light on its solution. The best that we can do is examine related areas and draw some analogies.

In 1922 the Court held that the right "to marry, establish a home and bring up children" was an essential liberty within the guarantees of the Fourteenth Amendment.[32] In 1925 a public school statute requiring attendance exclusively at state schools was declared unconstitutional on the ground that it unreasonably interfered "with the liberty of parents and guardians to direct the upbringing and education of children under their control."[33] This concept was later extended to include "the private realm of family life which the state cannot enter."[34] And in 1960 the Court declared, in very broad language, that where State action significantly encroached upon personal liberty, its action would be invalid unless the State had a compelling subordinating interest in the particular activity.[35] Finally, in *Griswold v. Connecticut*[36] the Court struck down the state's statute prohibiting the use of con-

31 N.Y. Times, Nov. 24, 1968, at 77, col. 1.
32 Meyer v. Nebraska, 262 U.S. 390 (1923).
33 Pierce v. Society of Sisters, 268 U.S. 510, 534-35 (1925).
34 Prince v. Massachusetts, 321 U.S. 158 (1944).
35 Bates v. Little Rock, 361 U.S. 516, 524 (1960).
36 381 U.S. 479 (1965).

traceptives. The statute was found to operate upon "an intimate relation of husband and wife" which came within the zone of privacy created by several fundamental constitutional guarantees, the penumbras of which gave protection to the sanctity of a man's home and the privacies of his life. The Court determined that the statute was aimed at use rather than regulation and therefore violated the principle that legislation must not be unnecessarily broad. This does not mean that judges are given a free rein to strike down state regulatory statutes. They must look to the collective conscience of our society in determining which rights are fundamental and therefore protected by the Constitution.

The result of these decisions is the evolution of the concept that there is a certain zone of individual privacy which is protected by the Constitution. Unless the State has a compelling subordinating interest that outweighs the individual rights of human beings, it may not interfere with a person's marriage, home, children, and day-to-day living habits. This is one of the most fundamental concepts that the Founding Fathers had in mind when they drafted the Constitution. No one will deny that a State has a valid interest in regulating the well-being of its inhabitants, especially when it is dealing with children, who are more susceptible to undesirable influences. We have also seen that a State may not unreasonably interfere with the intimate relations of its inhabitants. When deciding on the constitutional restraints imposed on a State's interference with individual rights, the vital question becomes one of balancing. It must be determined at what point the State is interfering with individuals and at what point it is exercising valid authority by regulating the well-being of children.

In his concurrence in *Griswold*, my brother Goldberg asked whether a decree requiring all husbands and wives to be sterilized after the birth of ten children would be valid. He answered the question in the negative.[37] But suppose that the husband and wife voluntarily submitted to sterilization. Would it then violate the Constitution? I think not. Does it therefore follow that voluntary destruction of the fetus is also protected from interference by the State? Perhaps—unless life is present so that the State's compelling subordinating interest in the life of one of its people predominates. However, I submit that until the time that life is present, the State could not interfere with the interruption of pregnancy through abortion performed in a hospital or under appropriate clinical conditions. I say this because State interfer-

[37] *Id.* at 482.

ence is permissible only if reasonably necessary to the effectuation of a legitimate and compelling State interest.[38] Prior to the time that life is present in the fetus, what interest does the State have? Procreation is certainly no longer a legitimate or compelling State interest in these days of burgeoning populations. Moreover, abortion falls within that sensitive area of privacy—the marital relation. One of the basic values of this privacy is birth control, as evidenced by the *Griswold* decision. Griswold's act was to prevent formation of the fetus. This, the Court found, was constitutionally protected. If an individual may prevent conception, why can he not nullify that conception when prevention has failed?

The common law courts uniformly held that an infant could not be the subject of a homicide until its complete expulsion from the body of the mother and the establishment of an independent existence.[39] The distinction between fetal life and independent life is that the latter has an independent circulatory system.[40] Hence, where the evidence showed that an infant was killed before its birth was complete or was killed by means used to assist in its delivery, it was not deemed a homicide.[41] Therefore, under the common law, abortion could not be murder. These concepts and distinctions have been somewhat eroded in recent years. At present the courts do not agree on the time when life begins. The courts, however, have held an *accoucheur* responsible for prenatal brain damage to an infant in a viable state.[42] In this line of cases, the courts have found that the unborn infant was a separate biological entity and hence a legal one in contemplation of law, indicating a departure from the requirement of an independent existence. From this reasoning the courts may well take the unborn child into their protective custody. Indications of such a trend are illustrated by the abolition of the viability rule in some jurisdictions[43] and the repudiation of the "live birth" doctrine by fourteen states.[44]

To say that life is present at conception is to give recognition to the potential, rather than the actual. The unfertilized egg has life, and if fertilized, it takes on human proportions. But the law deals in reality, not obscurity—the known rather than the unknown. When sperm

[38] *Id.* at 503 (concurring opinion).
[39] Morgan v. State, 148 Tenn. 417, 256 S.W. 433 (1923).
[40] State v. Prude, 76 Miss. 543, 24 So. 871 (1899).
[41] Evans v. State, 48 Tex. Cr. App. 589, 89 S.W. 974 (1905).
[42] Bonbrest v. Kotz, 65 F. Supp. 138 (D.D.C. 1946).
[43] *See* PROSSER ON TORTS (3d. ed. 1964).
[44] Del Tufo, *Recovery for Prenatal Torts: Actions for Wrongful Death*, 15 RUTGERS L. REV. 61 (1960).

meets egg life may eventually form, but quite often it does not. The law does not deal in speculation. The phenomenon of life takes time to develop, and until it is actually present, it cannot be destroyed. Its interruption prior to formation would hardly be homicide, and as we have seen, society does not regard it as such. The rites of Baptism are not performed and death certificates are not required when a miscarriage occurs.[45] No prosecutor has ever returned a murder indictment charging the taking of the life of a fetus. This would not be the case if the fetus constituted human life.

It has been urged that the courts are the proper forum to determine when life begins. I submit, however, that the professionals are better able to determine when life begins than are the courts. Tort cases might cast some light on the issue,[46] but I would prefer that the courts yield to the expert testimony of doctors. This testimony would vary greatly, but that is nothing new to our judicial system.

This is not a question that will be easily resolved. Few questions that reach the Supreme Court are. As was stated at the Christian Medical Society's Symposium, "professionals . . . do not wish to play God with human lives, whether in being or inchoate with life. But we can inform our judgment . . . by the widest interchange, airing and concensus. Humility is a large part of every professional's code."[47] It must be remembered that many imponderables are a part of Supreme Court adjudications.

Accommodation of conflicting doctrine is more difficult to achieve in the judicial than in the legislative process. Courts cannot reach out to reform our society. A problem comes to the Court in the form of a justiciable issue and is narrowly drawn, rendering the Court's ruling contracted and finespun. Legislatures, on the other hand, have such facilities for investigation as hearings and may address themselves to the necessities of broad social needs and the correction of evils, both probable and existing. As Mr. Justice Cardozo said, "Legislation can eradicate a cancer, right some hoary wrong, correct some definitely established evil, which defies the feebler remedies, the distinctions and the fictions familiar to the judical process."[48]

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[45] Schwartz, *Abortion and 19th Century Laws*, TRIAL June-July, 1967, at 41.

[46] Kwaterski v. State Farm Mut. Ins. Co., 34 Wis. 2d 14, 148 N.W.2d 107 (1967); Hatala v. Markiewicz, 26 Conn. Supp. 358, 224 A.2d 406 (1966). *Contra*, Norman v. Murphy, 124 Cal. App. 2d 95, 268 P.2d 178 (1954); Marko v. Philadelphia Transp. Co., 420 Pa. 124, 216 A.2d 502 (1966).

[47] Prof. Thomas Lambert, Jr., Editor-in-Chief, American Trial Lawyers Ass'n, former Prof. of Law, Boston Univ.

[48] B. CARDOZO, GROWTH OF THE LAW 134 (1924).

The courts work on a case-by-case system which deals with the past rather than the future. Society would not have the benefit of the sweeping effect of a statute, nor would the doctor have the protection that he is entitled to receive. The case method would be slow, expensive, and possibly disastrous. It is for the legislature to determine the proper balance, *i.e.*, that point between prevention of conception and viability of the fetus which would give the State the compelling subordinating interest so that it may regulate or prohibit abortion without violating the individual's constitutionally protected rights.

The present climate seems favorable for immediate legislative action. Five states have already led the way.[49] With appropriate action, many more will follow suit in liberalizing their abortion laws. But this process will take less talk and more action. As Nehru once said:

> I am tired of people who merely talk about things. However wise you may be, you can never enter into the spirit of a thing if you only talk about it and do nothing. Even scientists have a tendency to let a wonderful experiment remain an experiment once it has been performed. The next stage somehow does not come. They may well say that the next stage is somebody else's job, but I think if the scientist had a sense of practical application, he would either try to do it himself, or get somebody else to do it. This association of thought with action is, I think, of utmost importance. Thought without action is an abortion; action without thought is folly.[50]

[49] Georgia, Maryland, North Carolina, California, and Colorado.
[50] WISDOM, *supra* note 1.

LAW-MEDICINE NOTES

The Right to Health in National and International Law

WILLIAM J. CURRAN, J.D., S.M.HYG.

THE United States is in the midst of an upheaval of rights. The Supreme Court, which only a few years ago was primarily concerned with the distribution of powers between the federal government and the states, is now a court of civil rights. Throughout the world rising economic expectations are causing peoples to demand more personal and political rights and privileges.

In the World Health Organization, matters of human rights have been a central concern ever since the founding of the agency in 1946. The Preamble to the Constitution of WHO sets forth the basic principle: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

Since 1946, the subject of human rights has received attention in various international meetings and formal protocols, and declarations have recognized certain specific personal rights, the most important being incorporated in the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the International Covenant on Civil and Political Rights.

As a result of the International Conference on Human Rights in Teheran in 1968, the WHO was asked to make studies of the problems of human rights that could be occasioned by recent scientific discoveries and technologic advances. Action was taken by the WHO General Assembly in 1968 and again in 1970 concerning these matters. A preliminary report was prepared by the Secretary-General that collected the history of the subject in international agreements and surveyed the field broadly.[1] Among the newer areas examined in the report are the right of privacy, protection of human personality, experimentation on human subjects, deterioration of the environment, human-rights aspects of the delivery of health services, mental-health problems and nutrition. Nearly all these areas have been explored in these columns in the last few years.

The problem in WHO discussion of these subjects, of course, lies in the fact that nearly all of them are matters of national law rather than international legal powers. WHO and other international bodies can contribute greatly to the resolution of problems in these areas and can propose new formulations, but national action is nearly always required.

In the United States, recent legal developments have provided both greater general recognition of a right to health and direct legal actions concerning specific subjects. In the general area, one of the

most important pieces of legislation in Congress has been the Comprehensive Health Planning Act, now in full operation all over the nation on a co-operative, partnership basis among all levels of government. In the declaration of purpose of this legislation it is asserted, "The Congress declares that the fulfillment of our national purpose depends on promoting and assuring the highest level of health attainable for every person, in an environment which contributes positively to healthful individual and family living. . . ."[2]

The bills now before Congress proposing national health insurance and those expanding activities in the field of environmental health all speak in forceful tones about the people's right to health. There are also bills to require studies of the effect of technologic advances on health and human personality.

All physicians and all persons active in the health professions should be aware of the national and international legal activities in this field. These issues will be among the most important to come before the WHO, the UN, and our own national Congress this year.

References

1. United Nations General Assembly: Human Rights and Scientific and Technical Developments: Report of the Secretary-General: Addendum. New York, United Nations, November 30, 1970
2. Public Law 89-749. Comprehensive Health Planning Act of 1966: Findings and declaration of purpose

The rapid change which has taken place in the United States in the past few years in abortion laws and practices is reviewed, with special attention to judicial and legislative developments in America and in other countries. Lessons from the experiences of other countries are cited in terms of their relevance for this country.

ABORTION LAW REFORM AND REPEAL: LEGISLATIVE AND JUDICIAL DEVELOPMENTS

Ruth Roemer, J.D.

IN the three years from 1967 to 1970, a revolution has occurred in the abortion laws and practices in the United States. That revolution is still in process. Our once highly restrictive antiabortion laws have been reformed in 13 states and virtually repealed in four states. No other country has a statute which explicitly makes abortion a matter for decision by the woman and her physician. Although other countries permit abortion on request of the woman under certain circumstances, the four American states have pioneered in treating abortion, as a matter of law, like any other medical procedure.

As a result of recent developments, the United States has become a laboratory in which three different types of legal regulation of abortion can be compared and evaluated. We can also profit from the longer experience of other countries with abortion statutes of varying liberality, although account must be taken of differing family planning programs and systems of delivering health services.

Legislative Developments in the United States

Three kinds of modernized abortion laws have been enacted in the United States since 1967: (1) Twelve states have enacted all or part of the Model Penal Code first proposed in 1957 by the American Law Institute (ALI), under which abortion is not a crime when performed by a licensed physician because of substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the woman or that the child would be born with grave physical or mental defect, or in cases of pregnancy resulting from rape or incest.[1] (2) One state, Oregon, has expanded the American Law Institute grounds to include a sociomedical ground proposed originally by the American College of Obstetricians and Gynecologists[2] and patterned after a provision of the British Abortion Act of 1967,[3] i.e., that in determining whether or not there is substantial risk to the woman's physical or mental health, account may be taken of her total environment, actual or reasonably foreseeable.[4] (3) Four states—Alaska,[5] Hawaii,[6] New York[7] and the State of Washington (by referendum in November 1970)—have repealed all criminal penalties for abortion, provided only that the abortion is done early in pregnancy and by a licensed physician (Alaska, Hawaii, and Washington also stipulate that the opera-

tion must take place in a licensed hospital or other approved facility). Thirty-three states, however, still have laws making abortion a crime except when performed to save the life (or, in a few instances, the health) of the woman. None of these states even requires that the abortion be performed by a licensed physician.

The details of the new laws vary in their provisions.* The key developments relate to six general aspects:

1. All 17 states require that the abortion be performed by a licensed physician.

2. All the states with new laws, except Mississippi and New York, require that the abortion be performed in hospitals, with Kansas also permitting another place designated by law.[8] New York City has recently added the requirement that abortions be performed in hospitals or clinics, and not in doctors' offices.

3. All 17 states allow abortion to save the life of the woman, and also in pregnancies resulting from sex crimes.

All these 17 states (except Mississippi, which authorizes abortion only for rape or to save life) allow abortion to preserve the health or the physical or mental health of the woman. The sociomedical standard of the Oregon law mentioned above is a broader standard than the medical standard of the ALI-style laws.

Seven states set age limits on abortions for statutory rape. These limits may be lower than the age of consent. Thus, in California sexual intercourse with an unmarried girl below the age of 18 constitutes statutory rape; but if pregnancy results, it can be terminated only if the girl is below the age of 15.

All 17 states, except California and Mississippi, allow abortion for fetal abnormality.

4. The maximum time limits within which abortions may be performed vary from 16 weeks in Colorado, New Mexico, and Washington to 26 weeks in Maryland. In Oregon the time limit is 150 days; in Alaska and Hawaii, the fetus must be nonviable; and in New York the time limit is 24 weeks.

5. Medical approval by consultants, boards, or hospital therapeutic abortion committees is required in all states (except Mississippi) with ALI-style laws, although the Model Penal Code did not propose such procedures. In Oregon, two physicians must certify the circumstances justifying an abortion; in Alaska, Hawaii, and New York, only one physician is required.

6. New York and the following ALI-style states have no residency requirement: California, Colorado, Kansas, Maryland, Mississippi, and New Mexico. South Carolina, Hawaii, and the State of Washington have a 90-day residency requirement, and Arkansas, Delaware, North Carolina, and Virginia require four months' residency. Oregon requires that the patient be a resident, and Alaska requires 30 days' residency.

Actual practice, of course, may differ from the provisions of the statutes. In some places, doctors will not perform abortions as late as the statute allows. Nonresidents may not be welcomed even though the state has no residency requirement. Consents, consultations, and committee approvals may be required that are not specified in the statutes. It is also possible that residency requirements may not be strictly enforced and procedures may be more simple than those provided in the statute.

On the federal level, a bill introduced in Congress by Senator Packwood to legalize abortion throughout the nation made no progress. A recent policy enunciated for U.S. military hospitals, how-

* The provisions of all the abortion laws in the United States are summarized in a table, "Current Status of Abortion Laws—August 1, 1970," available upon request from the National Center for Family Planning Services, Health Services and Mental Health Administration, U. S. Department of Health, Education, and Welfare, Rockville, Maryland 20852.

ever, permits abortions and sterilizations for military personnel, active or retired, and their families, regardless of state or local laws.[9] In October, 1970, a White House task force on the mentally handicapped recommended that, in the interest of both maternal and child mental health, no woman should be forced to bear an unwanted child.

Judicial Developments in the United States

Legislative developments have been accompanied by an emerging body of court decisions on the constitutionality of antiabortion laws. The picture changes almost from day to day. As of autumn, 1970, five cases were on the U.S. Supreme Court docket, more than 20 cases were before three-judge federal courts; and, excluding the 20 states with federal cases, many of which also had state cases, another 11 states had cases pending in local courts.[10] The following important cases may be noted.

1. In September, 1969, the Supreme Court of California, in the first decision on the constitutionality of any antiabortion statute, invalidated the pre-1967 antiabortion law of California. In a four to three decision in *People* v. *Belous*,[11] the court held the statute unconstitutional on two principal grounds: (1) that the phrase, "necessary to preserve life," was so vague as to be violative of the due process requirements for a criminal law, and (2) that the law was in violation of a woman's fundamental rights to life and to choose whether to bear children. The latter follows from the U.S. Supreme Court's acknowledgment of a right of privacy or liberty in matters related to marriage, family, and sex.[12]

The critical issue defined by the California Supreme Court was whether the state had any legitimate interest in the regulation of abortion which would justify so deep an infringement of the fundamental rights of women. The court held that the state had no such compelling interest. The court said that it would not speak to the constitutionality of the current California Therapeutic Abortion Act, since Dr. Belous was charged under the old law. But one might well infer from the decision that the current law may be declared unconstitutional on similar grounds. The court did express the view, however, that the decision to terminate pregnancy under the 1967 Therapeutic Abortion Act was solely a medical one, and so long as the physician follows the procedural requirements of the act his judgment may not later be challenged by a jury or prosecutor in a criminal case.

2. Following the landmark decision of the California Supreme Court, the first decision of a federal court invalidating an antiabortion statute was handed down. In *U.S.* v. *Vuitch*,[13] the U.S. District Court for the District of Columbia held unconstitutional the District of Columbia statute which made abortion a felony unless performed by a licensed physician for the preservation of the mother's life or health. The court held this phrase so uncertain and ambiguous as to invalidate the statute for want of due process, and it recommended appeal to the U.S. Supreme Court. The opinion of Judge Gerhard A. Gesell in *Vuitch* emphasized, as the *Belous* decision had done, the woman's liberty and right of privacy in matters related to family, marriage, and sex and the necessity for demonstrating affirmatively the interest of the state in infringing on such rights. The opinion pointed out the discriminatory application of the statute with respect to women who are poor. This case is now on appeal to the U.S. Supreme Court, which has raised certain jurisdictional questions concerning the propriety of direct appeal to the Supreme Court without first proceeding to the U.S. Court of Appeals for the District of Columbia.

3. In addition to these two decisions which broke new legal ground, a number of other courts have invalidated pre-

ALI-style antiabortion laws. These cases have arisen in both federal and state courts.

Three-judge panels of federal district courts have held the pre-ALI-style laws of Texas[14] and Wisconsin[15] unconstitutional because of overbreadth. One court also held the statute void for vagueness, and both courts found the statutes an unconstitutional invasion of private rights and not justified by a compelling interest of the state. Contrary is one federal court which, in a two to one decision, upheld the antiabortion statute of Louisiana.[16]

Similar suits have been brought in federal courts involving the Arizona,[17] Illinois,[18] and New Jersey laws.[19] Suits challenging the Kentucky[20] and Minnesota[21] laws were dismissed on jurisdictional grounds, and the New York case was dismissed as moot on repeal of New York's antiabortion statute.[22]

State courts have also struck down pre-ALI-style laws. In Illinois, a judge of the criminal court held the abortion statute unconstitutional on grounds of vagueness and infringement on the woman's right to control her body.[23] In Pennsylvania, a county court judge found that that state's statute impinges on constitutionally protected areas and is so broad, unlimited, and indiscriminate that it fails to meet present-day tests for constitutionality.[24] In South Dakota, a circuit court condemned the statute because it interferes with private conduct without serving any vital interest of society.[25] In Michigan, the statute was found defective as infringing on the right of privacy in the physician-patient relationship and as possibly violative of the patient's right to safe and adequate medical treatment.[26] Contra, however, is the Massachusetts Supreme Judicial Court, which upheld the constitutionality of the state's statute prohibiting "unlawful" abortion against a charge of vagueness in a case sustaining revocation of a medical license.[27] Suits challenging other pre-ALI-style laws are still pending elsewhere.[28]

4. Attempts are currently being made to obtain an adjudication of the constitutionality of reformed ALI-style laws.[29] Thus far, only one reformed ALI-style law has been invalidated by a federal court—Georgia's 1968 abortion law. The U.S. District Court in Atlanta held unconstitutional those parts of the 1968 Georgia law that limited the woman's right to abortion to the three ALI grounds.[30] The basis of the court's decision was violation of the woman's right of privacy. Retained as a proper exercise of state power, however, were the requirements for medical consultation, hospital committee approval, hospital accreditation and exemption provisions, and the residency requirement.

On the state level, the California Therapeutic Abortion Act has been challenged in three cases. Two cases involving Doctors Robb and Gwynne are still pending, but preliminary decisions involving these doctors have held the California statute unconstitutional.[31] In *People* v. *Barksdale*, a municipal court in Alameda County held the current California law unconstitutional as violative of the equal protection clause of the 14th Amendment, as a vague and improper delegation of legislative authority to the Joint Commission on Accreditation of Hospitals, as discriminatory between the rich and the poor, as lacking the certainty required for a criminal statute with respect to the definition of mental illness, and as violative of the fundamental right of the woman to make a free choice whether or not to bear children.[32] In rejecting the argument that the state has a compelling interest in protecting the embryo, Judge T. L. Foley added the following poignant words:

> I might say that I belong to the religion that was just referred to, and I dislike to render this opinion. I must follow the law under my oath as a Judge. I am a Catholic which makes it very, very difficult—but my

oath of office calls for me to follow the law as stated and set out by the Appellate Courts of this State.[83]

The judicial picture is in constant flux as new cases are filed in federal and state courts; as the defense of unconstitutionality is raised in criminal prosecutions of doctors; as issues are raised concerning jurisdiction of courts and standing of plaintiffs to sue; and as decisions come down and appeals are taken.

On at least eight occasions, the United States Supreme Court has declined to review state court decisions that involved restrictive antiabortion laws.[84] One of these cases was the landmark decision of the California Supreme Court in *Belous*. On October 13, 1970, the court dismissed an appeal from the decision of a three-judge federal court holding the Wisconsin antiabortion statute unconstitutional.[85] Action by the court on the merits of abortion cases will be decisive, but it is possible that some of the cases will go off on questions of jurisdiction or on grounds other than the basic constitutional issues.

Although the final outcome cannot be predicted, three eventualities seem fairly certain. First, more and more states will change their laws in accordance with one or another of the three patterns now prevailing in the United States. Second, as in other nations of the world, moderately reformed laws will be amended to expand the grounds and to simplify the procedures; alternatively, antiabortion laws will be repealed. Third, in every state pressure will mount for making abortion available *de facto* as well as *de jure* to women, rich and poor, faced with the despair and desperation occasioned by unwanted pregnancy.

Recent Developments in Other Countries

The abortion laws of the world have been described on a five-stage continuum, ranging from the most permissive to the most restrictive.[86] Recent legislative changes show that more and more countries are liberalizing their laws or the interpretation of their laws all along this continuum.

1. *Abortion on the Insistence of the Woman*—No new jurisdictions have joined this category, except the four states in the United States discussed previously. The tightening of the Bulgarian law in 1968[87] in order to encourage population growth has been eased by a 1970 interpretation that allows abortion virtually on request for unmarried women and women having at least one child.[88] The hope is that this interpretation will reduce the number of illegal abortions. In these cases, the Bulgarian law resembles once again the most liberal laws of the USSR and Hungary. Now that the German Democratic Republic has liberalized its policy on abortion, as mentioned below, the only restrictive abortion statutes remaining in eastern Europe are those of Romania and Albania.

2. *Abortion on Social Grounds*—Two Scandinavian countries, Finland and Denmark, have liberalized their statutes further to include social grounds. The 1970 law in Finland specifies, in addition to medical and humanitarian reasons and the age of the mother (under 17 or over 40 or already the mother of four children), the following social ground:

> . . . when the delivery and care of the child would constitute, by reason of the conditions of existence of the woman and her family, as well as other circumstances, a change for her.[89]

A unique provision, relevant for all countries faced with expanding demand for abortions, requires the Finnish Department of Health to assure a sufficient number of qualified physicians and abortion hospitals and also impartial and uniform conduct from physicians.

The Danish law of 1970 permits abortion without authorization of a committee for reasons of life or health or in cases where the woman is over 38 or has four children under age 18 who

reside with her.[40] Authorization of a committee is required if the abortion is sought for sociomedical reasons, danger of fetal abnormality, or pregnancy resulting from a sex crime.

Sweden has not yet announced changes in its abortion law which have been under consideration for three years. Various alternatives are bruited about; that abortion may be permitted on the free choice of the woman provided she consults fully with an abortion service or, possibly, that the decision-making process may be decentralized in order to reduce the current delay which drives many women to illegal abortion.

3. *Abortion on Sociomedical Grounds*—Singapore has enacted sociomedical grounds for abortion along the lines of the British Abortion Act of 1967 but with approval required by a Termination of Pregnancy Authorisation Board, except when abortion is to preserve life or health.[41] This is the first Asian country, after Japan, to enact a liberalized abortion law.

The state of South Australia has also enacted an abortion lay modeled after the new British law.[42] Similar legislation is under discussion in New South Wales. A poll of general practitioners in Sydney, N.S.W., found that 957 women approached 92 general practitioners with requests for help in obtaining an abortion in a single year.[43] The fact that each general practitioner is confronted with a major dilemma of this kind ten times a year explains the high proportion of general practitioners in Sydney (76%) who favor liberalization of the law.

Since 1965, the German Democratic Republic has liberalized interpretation of its law, so that abortion is now authorized on sociomedical grounds.[44]

Legislation is still pending in India, which in the form proposed would allow abortion on sociomedical grounds and in cases of contraceptive failure.[45]

Experience in England, Wales, and Scotland during the first 18 months of the operation of the 1967 British abortion law reveals a shift from illegal to legal abortion, a shift from the private sector to the National Health Service, a slowing down of the illegitimacy rate (47% of all abortions in the first 18 months were for single women), and a narrowing of regional discrepancies in the operation of the law.[46] With the aid of voluntary pregnancy advisory services, abortion is being made available to women in all geographic areas and income groups.[47] Attitudes of gynecologists are becoming more sympathetic to applicants for abortion, as reflected by "the granting of National Health Service abortions on an increasing scale and by bodies such as the Royal College of Obstetricians and Gynaecologists taking a sincere, if belated, interest in contraception and sterilisation."[48] The most serious problem appears to be the universal need for improving contraceptive services and practices.

4. *Abortion on Medical Grounds*—Canada[49] and Peru[50] have broadened their abortion laws to permit abortion on the grounds of danger to the life or health of the woman.

5. *Abortion Only to Save the Life of the Woman*—This category has lost adherents. It will continue to do so as current law reform activities in many countries, e.g., France, increase in tempo.

Insights from Abroad

As the United States moves into the problems associated with providing medical care under its new abortion laws, several lessons from the experience of other nations seem relevant.

1. A liberal abortion law will transfer a number of illegal abortions to safe, clinical practice; but as long as restrictions in grounds or procedures remain, some illegal abortion will persist.[51] Initial experience under the California Therapeutic Abortion Act confirms this finding.[52] Therefore, experience in the

four states that have removed virtually all restrictions will be extremely important.

2. The earlier in pregnancy that abortion is provided, the less tendency there is to resort to illegal abortion. In eastern Europe, where abortion is generally done early in pregnancy, illegal abortion has been almost eliminated. The reverse is true in Sweden, where administrative procedures delay authorization for legal abortion. The U.S. laws specify time periods within which the abortion must be performed, but, in addition, women should be educated to seek abortions early and procedures should be simplified to achieve this objective.

3. On the basis of experience from eastern Europe, mortality from legal abortion can be anticipated to be low, particularly if performed early in pregnancy.[53] Complications in eastern Europe affect less than 3 per cent of patients.[54] England, as yet, has insufficient data on morbidity. One British authority has suggested that the requirement of a medical report within seven days after the abortion is too short a time to provide accurate information on complications.[55] Accurate records and reporting are essential.

4. As the British experience indicates, the climbing rate of illegitimacy in the United States may be slowed by increased availability of abortion. With nearly 10 per cent of all U.S. births in 1967 illegitimate, the option of abortion will need to be made widely known and accessible if the risks to health and the social disabilities of births to unmarried mothers are to be lessened.[56]

5. Uneven application of the law by reason of varying attitudes on the part of physicians can be anticipated from the experience in England and Norway. California's experience is similar. Continuing education programs for the medical profession and reforms in medical education are urgent.

6. Shortages of medical and auxiliary personnel may impede full implementation of new laws. In England, however, it was found that, if evenly distributed among all gynecologists, the increased number of abortions would not constitute an excessive workload.[57] It has been suggested that in the United States the load might be distributed among a larger group of physicians than those specialized in gynecology, if the social policy expressed by the new laws is to be implemented. Residents and interns on all services might be expected to perform abortions. Nurse-midwives might also be trained and utilized to perform early abortions. Such a decision would require amendment of the licensure laws in the three states that now license nurse-midwives and enactment of such licensure laws in other states.

7. England's experience shows the bottleneck that may result from shortage of facilities. Ambulatory care, as provided in other countries and as now demonstrated in the United States, is a promising solution for early abortions. Moreover, ambulatory treatment reduces the cost of abortions.

8. Evidence from Chile, South Korea, and Taiwan indicates that, in a country with a high or increasing abortion rate, the conditions are favorable for effective family planning programs.[58] A possible hazard is that the easy solution of abortion may generate a lack of responsibility in using contraceptives. Zeal to meet a long-neglected human need should be accompanied by efforts to use abortion as a means of encouraging effective contraception. A number of European statutes prohibit abortion if an abortion has been performed in the preceding six-month period. A more effective deterrent to repeated abortion would consist in aiding every woman who has an abortion to obtain and use effective methods of contraception.

The dynamic legislative and judicial developments in the laws governing abortion in the Untied States have generated

a ground swell of change. The action of the U.S. Supreme Court is crucial to the rate of progress, but, regardless of the outcome of cases pending before the court, the clock can never be turned back. Safe, legal abortion is now recognized as a fundamental right of women, a protection of maternal health and family welfare, and an assurance that every child is a loved and wanted child. Abortion, however, should be only one service in an array of services that should also include effective contraception, education for responsible sexual relationships, and health protection for mothers and children.

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REFERENCES

1. American Law Institute, Model Penal Code, sec. 230.3(2) (Proposed Official Draft, 1962). On Aug. 4, 1970, the Commissioners on Uniform State Laws issued a Second Tentative Draft of a Uniform Abortion Act, which authorizes abortions within 24 weeks after commencement of the pregnancy without specific grounds or after 24 weeks on the grounds set forth in the code. The 12 statutes incorporating all or part of the Model Penal Code are: Ark. Stat. Ann., secs. 41-301 to 41-310 (Supp. 1969); Cal. Health & Safety Code Ann., secs. 25950-54 (Supp. 1970); Colo. Rev. Stat. Ann., secs. 40-2-50 to 40-2-53 (Supp. 1967); Del. Code Ann., tit. 11, sec. 301 (1953) and Laws 1969; Ga. Code Ann., secs. 26-9920a to 26-9925a (1969); Kan. Stat. Ann., sec. 21-3407 (Supp. 1969) and Laws 1969; Md. Ann. Code, art. 43, secs. 149E to 149G (Supp. 1969); Miss. Code Ann., sec. 2223 (Supp. 1968); N. M. Stat. Ann., secs. 40A-5-1 to 40A-5-3 (Supp. 1969); N. C. Gen. Stat., secs. 14-44 to 14-45.1 (1969 Replacement Vol. 1B); S. C. Code, secs. 16-82 to 86 (1962) and Laws 1970; Va. Code Ann., secs. 18.1-62 to 18.1-62.3 (Supp. 1970). For discussion of these laws, see Lucas, Roy, "Laws of the United States" in *Abortion in a Changing World* (Robert E. Hall, Ed.), vol. I, p. 127, Columbia Univ. Press, 1970.
2. The American College of Obstetricians and Gynecologists has recently liberalized its position further to approve abortion on the decision of the patient and her physican without additional medical consultation. *AMA News*, Sept. 28, 1970.
3. Elizabeth II, Ch. 87 (1967) permitting termination of pregnancy on the opinion of two registered medical practitioners that continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to the physical or mental health of any existing children of her family greater than if the pregnancy were terminated.
4. S.B. 193, amending Ore. Rev. Stat., secs. 465.110, 677.188, and 677.190 and repealing sec. 163.060 (Laws 1969).
5. S.B. No. 527 repealing and re-enacting Alaska Stat., sec. 11.15.060 (Laws 1970).
6. Public Law No. 1 amending Hawaii Rev. Stat., ch. 768 (Laws 1970).
7. N. Y. Penal Law, sec. 125.05(3) (McKinney Supp. 1970-71).
8. Many states require that the hospital be not only licensed but accredited. For discussion of the unreasonableness and probable unconstitutionality of a requirement restricting performance of abortions to hospitals accredited by the Joint Commission on Accreditation of Hospitals, see Brief *Amici Curiae*, Ass'n for the Study of Abortion, Inc., Planned Parenthood Ass'n, et al., in Vuitch v. Maryland, Court of Special Appeals of Maryland, Sept. Term, 1970, No. 32, argued Sept. 28, 1970.
9. International Herald Tribune, p. 3, Aug. 19, 1970.
10. Personal communication from Roy Lucas, President and Associate Counsel, The James Madison Constitutional Law Institute, N. Y., Oct. 22, 1970.
11. 71 Cal. 2d 954, 458 P. 2d 194, 80 Cal. Rptr. 354 (1969), cert. denied, 397 U. S. 915 (1970).
12. Id. at 963, 458 P. 2d at 199.
13. 305 F. Supp. 1032 (D.D.C. 1969), ques. of juris. postponed to merits, 397 U.S. 1061, further juris. questions propounded, 399 U.S. 923 (1970) (No. 84, Oct. 1970 Term). On the practical availability of abortion under D.C. law, see court order requiring the D.C. General Hospital to give abortions to women meeting the standards for admission to the hospital. Doe v. Gen'l Hosp. of D.C., 313 F. Supp. 1170 (D.D.C. 1970), on motions to hold hospital officials in contempt, —— F. 2d ——, No. 24,011 (D.C. Cir. Mar. 20 and May 15, 1970).
14. Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970) (per curiam), appeal docketed,

39 U.S.L.W. 3151 (U.S. Oct. 7, 1970) (No. 808, Oct. 1970 Term).

15. McCann v. Babbitz, 306 F. Supp. 400 (E. D. Wis. 1969) (three-judge court convened), 310 F. Supp. 293 (1970) (per curiam) (on the merits), appeal dismissed, 400 U.S. ——, 39 U.S.L.W. 3132 (Oct. 13, 1970) (per curiam), perm. injunc. issued, —— F. Supp. —— (E.D. Wis. Nov. 18, 1970) (per curiam).
16. Rosen v. La. State Bd. Med. Examiners, 318 F. Supp. 1217 (1970) (Cassibry, J., dissenting).
17. Planned Parenthood Ass'n of Phoenix v. Nelson, Civ. No. 70-334 PHX (D. Ariz. Aug. 24, 1970) (per curiam).
18. Doe v. Scott, —— F. Supp. —— (N.D. Ill. 1971) (Illinois statute held unconstitutional as impermissibly vague and unduly infringing on the woman's right of privacy in restricting abortion during the first trimester of pregnancy.
19. YWCA v. Kugler, Civ. No. 264-70 (D.N.J., filed Mar. 5, 1970).
20. Crossen v. Breckenridge, Civ. No. 2143 (E. D. Ky.), dismissed June 15, 1970 by U. S. Judge Swinford, Lexington (Ky.) Herald, June 16, 1970. On appeal.
21. Doe v. Randall, 314 F. Supp. 32 (D. Minn. 1970), rehearing denied, 314 F. Supp. 36 (D. Minn. July 1, 1970) (per curiam), appeal docketed *sub nom.* Hodgson v. Randall, 39 U.S.L.W. 3115 (Sept. 21, 1970) (No. 728, Oct. 1970 Term).
22. Hall v. Lefkowitz, 305 F. Supp. 1030 (S.D.N.Y. 1969), dismissed as moot, Op. No. 36936 (S.D.N.Y. July 1, 1970) (per curiam).
23. People v. Anast, No. 69-3429 (Ill. Cir. Ct., Cook County, 1970) (Dolezal, J.).
24. Commonwealth v. Page, Centre County Leg. J. at 285 (Pa. Ct. Comm. Pl., Centre County July 23, 1970).
25. State v. Munson (S.D. 7th Jud. Cir., Pennington County Apr. 6, 1970) (Clarence P. Cooper, J.).
26. State v. Ketchum (Mich. Dist. Ct. Mar. 30, 1970) (Reid, J.).
27. Kudish v. Bd. of Registration in Med., 355 Mass. ——, 248 N.E. 2d 264 (1969). Similar decisions have upheld the Iowa and Vermont statutes as not unconstitutionally vague.
28. See, for example, Arnold v. Sendak, No. IP 70-C-217 (S.D. Ind., filed Mar. 29, 1970); Rodgers v. Danforth, Civ. No. 18360-2 (W.D. Mo., filed May 15, 1970); Steinberg v. Brown, No. C-70-289 (N.D. Ohio); Doe v. Rampton, Civ. No. 234-70 (D. Utah, Sept. 14, 1970). (Temporary restraining order against enforcement of Utah statute issued).
29. Corkey v. Edwards, Civ. No. 2665 (W.D.N.C., filed May 12, 1970); Gwynne v. Hicks, Civ. No. 70-1088-CC (C.D. Calif., filed May 18, 1970); Doe v. Dunbar, Civ. No. C-2402 (D. Colo., filed July 2, 1970), juris. granted —— F. Supp. —— (D. Colo. Dec. 22, 1970). (One of the attorneys in the Colorado suit challenging the first ALI-style law enacted is Richard D. Lamm, sponsor of the reformed legislation in the Colorado Legislature.)
30. Doe v. Bolton, —— F. Supp. ——, Civ. No. 13676 (N.D. Ga. July 31, 1970) (per curiam), appeal docketed, 39 U.S.L.W. 3227 (U.S. Nov. 17, 1970) (Nos. 971, 973, Oct. Term 1970).
31. People v. Robb, Nos. 149005 & 159061 (Calif. Mun. Ct., Orange County, Jan. 9, 1970) (Mast, J.); People v. Gwynne, No. 173309 (Calif. Mun. Ct., Orange County, June 16, 1970) (Thomson, J.); People v. Gwynne, No. 176601 (Calif. Mun. Ct., Orange County, Aug. 13, 1970 (Schwab,
32. People v. Barksdale, No. 33237C (Calif. Mun. Ct., Alameda County, Mar. 24, 1970) (Foley, J.).
33. Ibid.
34. The Jurdisdictional Statement filed in the U.S. Supreme Court on Oct. 7, 1970 by Roy Lucas et al. in Roe v. Wade, 314 F. Supp. 1217 (N.D. Tex. 1970) (per curiam), No. 808, Oct. 1970 Term cites the following cases at p. 18, n. 30: Muncie v. Missouri, 398 U.S. 938 (June 1, 1970), denying cert. to 448 S.W. 2d 879 (Mo. 1970); California v. Belous, 397 U.S. 915 (Feb. 24, 1970), denying cert. to 71 Cal. 2d 954, 458 P. 2d 194, 80 Cal. Rptr. 354 (1969); Molinaro v. New Jersey, 396 U.S. 365 (Jan. 19, 1970) (per curiam), dismissing appeal from 54 N.J. 246, 254 A. 2d 792 (1969); Knight v. Louisiana Bd. of Medical Examiners, 395 U.S. 933 (June 2, 1969), denying cert. to 252 La. 889, 214 So. 2d 716 (1968) (per curiam); Morin v. Garra, 395 U.S. 935 (June 2, 1969), denying cert. to 53 N.J. 82 (1968) (per curiam); Moretti v. New Jersey, 393 U.S. 952 (Nov. 18, 1968), denying cert. to 52 N.J. 182, 244 A. 2d 499 (1968); Fulton v. Illinois, 390 U.S. 953 (Mar. 4, 1968), denying cert. to 84 Ill. App. 2d 280, 228 N.E. 2d 203 (1967); Carter v. Florida, 376 U.S. 648 (Mar. 30, 1964), dismissing appeal from 150 So. 2d 787 (Fla. 1963).
35. McCann v. Babbitz, 310 F. Supp. 293 (E.D. Wis. 1970), appeal dismissed, 400

U.S. ——, 39 U.S.L.W. 3132 (Oct. 13, 1970) (per curiam), supra note 15.
36. Roemer, R. Abortion Law: The Approaches of Different Nations. A.J.P.H. 57,11:1906 (Nov.), 1967; Roemer, R. "Abortion Laws of the World: Recent Trends and Policy Issues" in *Abortion in a Changing World*, supra note 1 at p. 119.
37. Bulgaria. Law of 16 Feb. 1968, Int. Dig. Health Leg., vol. 19, pp. 589-602, 1968.
38. David, Henry P. *Family Planning and Abortion in the Socialist Countries of Central and Eastern Europe, A Compendium of Observations and Readings*, p. 69, The Population Council, New York, 1970.
39. Finland. Law No. 239 of 24 Mar. 1970 on the interruption of pregnancy, Int. Dig. Health Leg., vol. 21, no. 4, 1970.
40. Denmark. Law of 18 Mar. 1970, Int. Dig. Health Leg., vol. 21, no. 3, 1970.
41. The Abortion Act of Singapore, 1969, Republic of Singapore, passed 29 Dec. 1969 and assented to by the President 31 Dec. 1969, Int. Dig. Health Leg., vol. 21, no. 4, 1970.
42. South Australia. An Act to amend the Criminal Consolidation Act, 1935-1966, No. 109 of 1969, assented to 8 Jan. 1970.
43. Sussman, William, and Adams, Anthony I. General Practitioners' Views on Pregnancy Termination. M. J. Australia, pp. 169-173, July 25, 1970.
44. Supra note 38 at p. 233.
45. India. The Medical Termination of Pregnancy Bill, 1969 (Bill No. XXII of 1969).
46. Diggory, Peter, and Potts, Malcolm. Preliminary Assessment of the 1967 Abortion Act in Practice. Lancet, pp. 287-291, Feb. 7, 1970.
47. Id. at p. 290.
48. Ibid.
49. Stats. of Canada, C. 38, sec. 18 (1968-69).
50. Peru. Decree-Law No. 17505 of 18 Mar. 1969, Ch. 11, sec. 19, Int. Dig. Health Leg., vol. 21, p. 137 at 140, 1970.
51. Potts, D. Malcolm. "Induced Abortion—the Experience of Other Nations" in *Population Control, Implications, Trends, and Prospects*, Proceedings of the Pakistan International Family Planning Conference at Dacca, Jan. 28-Feb. 4, 1969, p. 241, Sweden Pakistan Family Welfare Project, Lahore, West Pakistan, March 1969.
52. See California State Department of Public Health, *A Report to the 1970 Legislature, Third Annual Report on the Implementation of the California Therapeutic Abortion Act*, p. 5, estimating that 81,600 abortions were done on California women in 1968, of which 76,600 were illegal. Even substantially increased numbers of therapeutic abortions—which have occurred since 1968—will not eliminate an illegal abortion problem of this magnitude. The source of the estimated number of illegal abortions was a carefully controlled study in North Carolina. Abernathy, James R.; Greenberg, Bernard G.; and Horvitz, Daniel G. "Estimates of Induced Abortion in Urban North Carolina." Demography, vol. 7, no. 1, p. 19, Feb., 1970.
53. See Tietze, Christopher. "Abortion Laws and Practices in Europe," *Excerpta Medica International Congress*, Series No. 207, April, 1969; and Tietze, Christopher, "Mortality with Contraception and Induced Abortion," *Studies in Family Planning*, vol. 45, p. 6, Sept. 1969.
54. Supra note 38 at p. 253.
55. Supra note 46 at p. 290.
56. On the higher risks of the unmarried mother and her child, see *Health Aspects of Family Planning*, Report of a WHO Scientific Group, World Health Organization Tech. Rep. Series, No. 442, p. 10, Geneva, 1970.
57. Supra note 46 at p. 288.
58. Engstrom, Lars Erik. "Abortion as a Method of Population Control," in *Population Control, Implications, Trends, and Prospects*, supra note 51 at p. 240.

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IV.

MEDICAL AND SOCIAL SCIENCE STUDIES ON ABORTION PRACTICES

The "Perfect Contraceptive" Population

The extent and implications of unwanted fertility in the United States are considered.

Larry Bumpass and Charles F. Westoff

Recent discussions of population pol- have raised and sharpened the ques- of unwanted fertility in the United es (*1*). The issue is whether the ination of unwanted fertility would e a significant effect on our rate of ulation growth, and the discussion revolved in part around what might called the demographic implications 'perfect contraception." We are not esting that such a technological de- pment is in sight, or that, if it were, we would not have to be concerned about problems of distribution and use. The "perfect contraceptive" population is simply a model in which couples can avoid having more children than they want and do not have children before they want them. In the broader sense we are visualizing the "complete fertility controlling population" rather than the "perfectly contraceptive population." The achievement of such a state of affairs might well require social policies for the development of more effective contraceptive techniques and more efficient distribution systems as well as the legalization of abortion on request. However, this article is focused on *implications* of the elimination of unwanted fertility rather than on specific policies necessary to realize this goal.

We make no artificial assumptions about fecundity; we assume that the current incidence of subfecundity (less than normal capacity to reproduce) in the United States will continue. Also, we are *not* assuming that every couple will practice contraception or that all couples will begin using contraception at the same stage of their marriage. The system is completely voluntary. The only condition we are imposing is that couples can control their fertility completely in the sense that they can, within the limits of physiological capacity and variability, have the number of children they want, when they want them. If a husband and wife prefer to have chil-

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Table 1. Percentages of births occurring between 1960 and 1965 reported to have been unwanted, by birth order and race. The values in parentheses are numbers of births.*

Race	All	Birth order					
		1	2	3	4	5	6+
		1) Unwanted by both spouses					
Total	17	4	6	18	25	39	45
White	14	3	5	17	23	36	39
Negro	31	9	17	24	37	51	61
		2) Unwanted by at least one spouse					
Total	22	5	10	24	35	49	55
White	19	4	7	23	32	46	48
Negro	41	15	24	37	51	61	72
		3) Medium estimate, average of categories 1 and 2					
Total	19 (4,264)	5 (1,090)	8 (1,020)	21 (792)	30 (532)	44 (328)	50 (502)
White	17 (3,091)	4 (839)	6 (779)	20 (602)	28 (397)	41 (215)	43 (259)
Negro	36 (1,108)	12 (234)	20 (229)	30 (180)	44 (131)	56 (107)	66 (227)

* The 1965 NFS double-sampled Negroes. Consequently, for measures computed for the total sample, the data for non-Negroes are weighted by a factor of 2. In this and all subsequent tables based on the NFS, the number of cases reported for the total are unweighted and represent the actual number of sample cases on which the statistics are based. Non-whites other than Negroes are included in the total.

dren right away or want a large family, they may use no contraception at all. On the other hand, if they wish to control their fertility (a virtually universal wish in the sense that practically all exposed couples in the United States use contraception sooner or later) (*2*), they shall be able to practice completely effective and completely acceptable contraception continuously. "Completely effective" means that the failure rate is zero; "completely acceptable" means that the use of contraception carries no costs of any kind—economic, social, or psychological—and that its use would be interrupted only for the purpose of conceiving. While such conditions are Utopian, the model provides a useful framework for assessing the implications of current levels of unwanted fertility in the United States for the rate of population growth.

Radically different policy implications flow from (i) the position that achieving a zero or near-zero rate of population growth requires changing the number of children couples want, and (ii) the position that eliminating unwanted births is sufficient. Consequently, it is important that we evaluate the number of unwanted births in the United States on the basis of the most recent detailed data available. Our estimates are based on the 1965 National Fertility Study (NFS), an interview survey of a probability sample of 5600 married women throughout the nation (*3*).

Measurement of Unwanted Fertility

Reliable reports on unwanted births are difficult to obtain, since the admission that a birth was unwanted reflects on the respondent's ability to control fertility and perhaps also on the status of the child. Unwanted fertility was measured in the 1965 NFS on the basis of questions about the circumstances of each pregnancy. Women who reported the use of some contraceptive method preceding a pregnancy were asked, "Under which of these circumstances did this pregnancy occur?" A card listing the following categories was shown to the respondent:

1) While using a method and did not want to become pregnant at that time.
2) While not using a method but did not want to become pregnant at that time.
3) When stopped using a method in order to have a child.

Women who reported circumstances 1 or 2 were then asked, "Before you became pregnant this time, did you want to have a child (or another child) sometime?" and "Did your husband want to have a child (or another child) sometime?"

Women who reported not having practiced contraception prior to pregnancy were asked: "Was the *only* reason you did not use any method then because you wanted to have a baby as soon as possible?" Those who answered "No" were asked the same questions as the other group about whether they had wanted another child sometime.

Since couples are not always in agreement on the desirability of having additional children, alternative definitions of "unwanted" fertility are possible. A minimal definition would require that both spouses had been reported not to have wanted another child before pregnancy occurred. A broader definition would require only that one spouse had been reported not to have wanted an additional child. When husband and wife disagree on this question, some couples will intentionally have another child, others will not. It seems reasonable to assume that the proportion of unwanted births lies somewhere between estimates resulting from these two definitions, and that the average of the two constitutes a best estimate. We use this estimate throughout the text, although the consequences of alternative definitions are reported in several tables for the reader's evaluation.

To what extent are these measures of unwanted fertility reliable and valid? As part of the 1965 NFS, a subsample of the original sample of women was re-interviewed 3 to 5 months later, to assess the reliability of survey data on fertility and family planning. The percentage of births classified as unwanted differs by 0.3 percent in the two interviews. Checks for internal consistency reveal that none of the women who reported that their last child was unwanted replied (to a different question) that they intended to have additional children. In addition, the NFS estimate is consistent with reports of other fertility surveys based on differing measurement techniques (*4*).

An indirect check on the validity of our estimates can be made in terms of contraceptive efficacy. When we consider women who are near the end of the childbearing stage (40 to 44 years of age), the percentage classified as having experienced at least one unwanted birth implies, even when allowance is made for underreporting, an average contraceptive efficacy that is improbably high (*5*). Realistic assumptions about the level of contraceptive efficacy of this population would very likely lead to a figure for the proportion who had experienced at least one unwanted birth that is higher than the estimate obtained by the measures used here (*6*). This is independent evidence that there is considerable rationalization in the report of unwanted births and that our estimates of unwanted fertility are not likely to be too high.

Incidence and Characteristics of Unwanted Fertility

In order to focus on the most recent picture for which data are available, we have limited the analysis in this section to births which occurred between the beginning of 1960 and the time of interview, the autumn of 1965.

It is evident from the data of Table 1 that unwanted births comprised a sub-

proportion of total births during
ars. Our estimates indicate that
of all births and more than
d of Negro births between 1960
5 were unwanted. As one would
the proportion of unwanted
increases rapidly with birth
Almost one-third of all fourth-
births and one-half of all sixth-
her-order births were unwanted;
groes the corresponding propor-
re nearly one-half and two-thirds.
high level of unwanted births
Negroes indicates the magni-
of the burden of unwanted de-
nts that is borne by this popu-
but the problems of unwanted
are substantial among whites
ll.

incidence of unwanted births is
vely related to both education and
e (Tables 2 and 3). In general,
roportion of unwanted births is
ximately twice as high among
with less than a high school edu-
as among wives who have at-
d college. By income, the propor-
of births reported as unwanted
little for families whose 1964
ne was over $5000, but it is more
twice as high for families with incomes of less than $3000 as for those with incomes of over $10,000. This differential is particularly marked among Negroes.

We have approximated the Social Security Administration's definition of poverty (*7*), and the results are presented in Table 4. Since family size is one component of that definition, many couples would not have been classified as poor were it not for their having had unwanted children. Consequently, the results indicate the coincidence of poverty and unwanted births rather than a propensity of the "poor" to have unwanted children. Among the "poor" in 1965, unwanted births constituted almost two-fifths of all births and three-fifths of all sixth- and higher-order births; among the "non-poor" one out of every seven births was unwanted among whites and one out of every five among Negroes (*8*).

Estimates for All Women

The foregoing analysis is based on a sample of married women living with their husbands in 1965; consequently, births to women not living with their husbands and most illegitimate births are not represented (*9*). In the absence of reliable data on the subject, our procedures are based on the assumption that the incidence and birth-order distribution of unwanted births are the same for such births as for births reported by wives now living with their husbands. This undoubtedly is a bias in the direction of underestimating the extent of unwanted fertility.

We prepared our estimates separately by race and birth order and then summed them to obtain the total. We estimate that in the period 1960 to 1965 there were 4.7 million births that would have been prevented by "perfect contraception." These births represent one-fifth of all births during the period. Approximately 2 million of these unwanted births occurred among the poor and the near-poor, and half of these among the Negro poor and near-poor (Table 5).

Timing Failures

While the level of unwanted births is high, the data of Table 6 make it clear that many desired births are tim-

2. Percentages of unwanted births (medium estimate) occurring between 1960 and 1965, by wife's education, by race, and by birth r. The values in parentheses are numbers of births.*

Wife's education	Total	White	Negro	Birth order for total					
				1	2	3	4	5	6+
than 12 years	26 (1,842)	21 (1,153)	42 (693)	5 (341)	11 (380)	26 (339)	31 (249)	42 (188)	54 (335)
ears	16 (1,742)	14 (1,361)	28 (358)	4 (525)	6 (437)	20 (232)	32 (207)	48 (102)	44 (139)
ge	13 (688)	11 (577)	25 (95)	4 (223)	8 (202)	16 (121)	22 (76)	42 (38)	45 (28)

e footnote to Table 1.

le 3. Percentages of unwanted births (medium estimate) occurring between 1960 and 1965, by 1964 family income, birth order, and e. The values in parentheses are numbers of births.*

Income (dollars)	Total	White	Negro	Birth order for total				
				1	2	3	4	5+
s than 3,000	34 (436)	27 (178)	42 (244)	10 (95)	14 (79)	38 (62)	42 (48)	57 (152)
00-4,999	24 (1,032)	18 (562)	39 (446)	7 (282)	12 (224)	23 (170)	30 (122)	56 (234)
00-6,999	16 (1,289)	14 (977)	30 (298)	3 (358)	6 (335)	22 (248)	30 (144)	44 (204)
00-9,999	16 (867)	16 (772)	28 (84)	4 (214)	4 (226)	20 (174)	29 (121)	42 (132)
000 and over	15 (561)	15 (541)	16 (19)	3 (123)	9 (143)	14 (120)	26 (88)	34 (87)

See footnote to Table 1.

ble 4. Percentages of unwanted births (medium estimate) occurring between 1960 and 1965, by poverty status, race, and birth order. The lues in parentheses are numbers of births.*

Poverty status	Total	White	Negro	Birth order for total					
				1	2	3	4	5	6+
or and near-poor	32	25	46	7	14	28	34	46	56
Poor	37 (861)	31 (346)	47 (494)	9 (135)	16 (179)	30 (213)	35 (186)	47 (178)	61 (337)
Near-poor	23 (424)	16 (253)	40 (170)	5 (137)	10 (151)	22 (130)	32 (77)	43 (63)	42 (120)
on-poor	15 (2,979)	15 (2,492)	22 (444)	4 (1,674)	6 (1,481)	20 (1,061)	28 (670)	42 (308)	42 (320)

See footnote to Table 1.

Table 5. Estimated numbers (in thousands) of unwanted births in the United States between 1960 and 1965,* by birth order, race, and poverty status.

Race	All birth orders	Poor and near-poor	Non-poor	Birth order for total					
				1	2	3	4	5	6+
			1) *Unwanted by both spouses*						
Total	4,050	1,738	2,312	261	369	831	742	669	1,178
White	2,828	838	1,990	176	236	677	576	499	664
Negro	1,103	836	267	82	116	126	151	157	471
			2) *Unwanted by at least one spouse*						
Total	5,321	2,214	3,107	376	553	1,102	1,031	841	1,418
White	3,736	1,062	2,674	234	375	879	800	632	816
Negro	1,432	1,067	365	132	163	193	206	186	552
			3) *Medium estimate, average of categories 1 and 2*						
Total	4,685	1,976	2,709	319	461	966	886	755	1,298
White	3,282	950	2,332	205	306	778	688	566	740
Negro	1,267	951	316	107	139	159	178	172	512

* Proportions of unwanted births in the NFS sample are applied to vital statistics data for the United States (see Appendix for technical details). In the absence of official data on births by poverty status, we have estimated the number of unwanted births to the poor and near-poor on the basis of the distribution by poverty status of unwanted births in the NFS sample.

ing failures. A birth was classified as a timing failure when it was reported as wanted but not the result of the deliberate interruption of contraception.

Of wanted births occurring between 1960 and 1965, two-fifths would have occurred later if their timing had been controlled. The short-run demographic effects of the prevention of timing failures depend upon the length of time considered and the assumed time required for the transition to perfect contraception (contraception enabling every couple to avoid failures in regulating family size and in timing births). For example, if perfect contraception had been universally employed at the beginning of 1960, perhaps 7 percent of the wanted births that occurred between 1960 and 1965 would have been delayed until after 1965. This estimate is based on the assumption that the average length of a successfully planned interval is 1 year longer than that of an interval in which timing was not controlled. If births are delayed, total fertility for each cohort (women born in the same year) being kept constant, there is a dip in births while the change occurs and no subsequent "makeup" of the lost births until the mean age of childbearing falls. When the transition is complete, a certain number of births will have been deferred to subsequent years, and this number will remain fixed so long as the new spacing pattern persists.

After the transitory dip is over, the number of births may be affected by increased spacing (total fertility for each cohort being kept constant) because fertility is centered on a lower portion of the stable age distribution. This effect is negligible in a low-mortality population reproducing at a rate near replacement.

There is, however, one possible indirect consequence of such timing changes that has potential long-run significance. It has been suggested that the longer a birth is delayed, the less likely a woman is to have that birth or a subsequent birth (*10*). The longer a couple puts off having a "wanted" child, the more opportunity the wife has to acquire role patterns at variance with early child-care responsibility. At some point that birth, or a desired subsequent birth, may no longer seem so desirable. In addition, the delay of a desired birth increases the possibility that the birth will be prevented by subfecundity. In any event, the major demographic effect of the universal use of contraception would be the prevention of unwanted births. In the next section we will discuss the long-run implications of this effect.

Table 6. Percentages of wanted births classified as timing failures,* by birth order and race. The values in parentheses are numbers of births.†

Race	All birth orders	Birth order					
		1	2	3	4	5	6+
Total	43 (3,217)	38 (1,020)	42 (906)	50 (587)	50 (335)	44 (162)	47 (207)
White	42 (2,513)	36 (805)	40 (722)	48 (466)	48 (269)	42 (116)	46 (135)
Negro	56 (657)	50 (199)	61 (174)	59 (114)	62 (64)	57 (42)	50 (64)

* A birth was classified as a timing failure when reported as wanted but not the result of deliberate interruption of contraception. † See footnote to Table 1.

Long-Run Implications for U.S. Growth Rate

Since nearly 20 percent of all recent births were unwanted, the elimination of unwanted births could substantially reduce our future growth rate. However, the size of this reduction would depend upon the number of children that women now entering the childbearing years will ultimately want to have.

Viewed from a cohort perspective, for women who were near the end of their childbearing years in 1965 (ages 35 to 44), the elimination of births reported to have been unwanted would have reduced their fertility from 3.0 to 2.5 births per woman. Since an eventual zero rate of population growth would require cohort fertility of about 2.25 births per woman, the elimination of unwanted births would not have been sufficient to establish exact replacement for this cohort, but it would have resulted in considerable progress toward that objective. The proportion of unwanted births (16 percent) reported by this cohort—the figure used to calculate the above estimate of 2.5 births—is lower than the proportion reported for all women in the period 1960–1965, probably due to additional underreporting of unwanted births resulting from the longer period of time that had elapsed since the events in question in the case of the women aged 35 to 44. The demographic effect of eliminating unwanted births is probably greater than we infer because of this underreporting by older women and the probable underreporting of unwanted births in general, and also because the additional children born to these older women before they reach menopause will undoubtedly be mostly unwanted.

The above estimate is based on the experience of married women whose childbearing took place in the high fertility period of the early 1950's. Under circumstances of perfect contraception, women now entering the childbearing years might decide to have larger families than women who have preceded them would have had if they had complete control of fertility, but this does not seem likely. Rapid diffusion of use of the pill has continued since 1965, and one of the consequences of this diffusion may be reduction of the number of "desired" as well as of unwanted children. As women are able increasingly to postpone pregnancy and to enter into nonfamilial roles (particularly employment), many may prefer to have

amilies than they would otherse chosen. If, in addition, there ad toward nonfamilial female ere may be strong pressures any upsurge in the average ze that would be achieved by n women with complete fertility

t there are already indications ultimate family size of the most ohorts may be lower than that ding cohorts (*11*). This decline the result of some reduction in d births, in some reduction in ber of children women want to r in some combination of these Predicting the fertility of young is always precarious, but it ikely to us that, under the asn of perfect contraception, the e number of children today's women would bear would be the number inferred, under the ssumption, for women who were n the ages of 35 and 44 in 1965. is some evidence from longitutudies that success in the control tility results in smaller families vere originally desired (*12*).

vever, it is very important that ep in mind the legacy of past y when considering the potential ations, for the U.S. growth rate, e elimination of unwanted births. if exact cohort replacement could hieved, the population would not diately cease to grow. The time red for cohort fertility to reach replacement rate would depend the speed with which universal ct contraception was achieved. the replacement rate had been ed, it would be some time before ffects of past fertility on the age ture would level off. Frejka has ared estimates directly relevant to question (*13*). He demonstrates that e cohort comprised of women enter- their childbearing years between 5 and 1970 and all subsequent cos were to achieve a cohort fertility exact replacement, the population ld continue to grow at least until year 2035, with a resultant increase ize of 40 to 50 percent.

n summary, the elimination of unted births would lead to a reduced wth rate for the United States, bar- a marked increase in the average nber of children desired. However, n if cohort replacement were ieved (perhaps as a consequence of er developments as well), a zero wth rate for the United States could not be achieved for over 60 years, by which time the population would number over 280 million. The longer it takes to achieve universal perfect contraception, the longer it will take to reduce our growth rate, and the larger, of course, will be the eventual size of our population.

In terms of the implications for a population policy goal of zero growth, our findings do not imply that the task of influencing people to want fewer children should be ignored, especially since this number could shift upward again. However, the elimination of unwanted births would have considerable demographic effect, it would be desirable in human terms, and it would probably be a more readily attainable objective.

Appendix: Comparison with Other Measures

Since the conclusions reached by the use of more conventional measures of "desired" or "ideal" family size (*14*) differ radically from those reached by our procedure of inferring the desired number of children, a word on the differences in the two approaches is necessary. The first is used typically in surveys with married women of all ages within the reproductive span and with varying numbers of children; in this approach the woman is simply asked how many children she would like to have or how many she would consider ideal for herself, or, in some instances, for the average American family. Our approach has been to infer the desired number of children by subtracting the number of unwanted births from the total number of births. The latter procedure results in considerably lower estimates of the number desired. For example, married women aged 35 to 44 in 1965 reported, through the direct approach, a "desired family size" of 3.4 children, as compared with 2.5 children as estimated by our procedure.

In general, the difference is probably attributable to real differences reflected by the two types of measurement. In the direct approach, desired family size relates to the time of the survey and is based on the respondent's fertility history and on her and her husband's adjustment to it. It is not at all inconsistent for a couple that has had a child that had been unwanted to state later, on the basis of a satisfactory (even beneficial) adjustment to the unwanted birth, that the size of their family is what they desire. To infer that this is the number of children such couples would have wanted under the conditions of perfect fertility control would be erroneous. For couples early in their life cycle, the measure of "desired family size" may be highly invalid as a predictor of the number of children they would have if they could control their fertility. The average family size desired by young couples corresponds closely with the eventual average family size for these couples, regardless of the number of unwanted births; this suggests that the number of children young couples desire before the experience of childrearing may be largely a reflection of the observed sizes of the families of other couples of similar social status.

On the other hand, when desired family size is measured by subtracting (for women past the childbearing years) the number of unwanted births from the number of children borne, the time focus is on evaluation of the event at the time of pregnancy. Although the responses may still be influenced by intervening experience, this bias should be much less than the bias when the reference is to the present, or to the future conditioned by the present.

The two types of variables can be measured independently, since about half of the women who reported an unwanted birth also said they would not have preferred to have fewer children than they had. Both measures are useful, but it seems to us that the approach we have defined in this article is the more suited to the task of assessing the demographic implications of perfect contraception.

References and Notes

1. J. Blake, *Science* **164**, 522 (1969); O. Harkavy, F. S. Jaffe, S. Wishik, *ibid.* **165**, 367 (1969).
2. C. F. Westoff and N. B. Ryder, in *Fertility and Family Planning: A World View*, S. J. Behrman, L. Corsa, R. Freedman, Eds. (Univ. of Michigan Press, Ann Arbor, 1969), p. 394.
3. For a description of this sample see N. B. Ryder and C. F. Westoff, *Science* **153**, 1199 (1966). A high level of unwanted fertility in the United States has been reported on the basis of national fertility studies; in this article we draw attention to the implications of the current patterns of unwanted births. For the earlier reports see R. Freedman, P. K. Whelpton, A. A. Campbell, *Family Planning, Sterility and Population Growth* (McGraw-Hill, New York, 1959), pp. 100–153; P. K. Whelpton, A. A. Campbell, J. E. Patterson, *Fertility and Family Planning in the U.S.* (Princeton Univ. Press, Princeton, N.J., 1966), pp. 221–275, 361–370; N. B. Ryder and C. F. Westoff, *Demography* **6**, 435 (1969).
4. N. B. Ryder and C. F. Westoff, *Reproduction in the United States: 1965* (Princeton Univ. Press, Princeton, N.J., in press), chap. 14, table 5.
5. Ryder notes that these levels of unwanted fertility are consistent with a regulatory pro-

cedure that is 99 percent perfect. See N. B. Ryder, "The time series of fertility in the United States," paper presented before the International Union for the Scientific Study of Population, London, 1969.

6. R. G. Potter and J. M. Sakoda, *Demography* 3, 450 (1966).
7. M. Orshansky, *Soc. Secur. Bull.* (March 1968).
8. These estimates of the percentages of unwanted births among poor and non-poor, and the estimates of the gross number of unwanted births in the period 1960 to 1965, discussed in the next section, are of the same order of magnitude as values presented in a preliminary approximation by F. S. Jaffe and A. F. Guttmacher, *Demography* 5, 910 (1968).
9. Our sample design for a new national study in 1970 which calls for a sample of "ever married" women will provide a better basis for making these estimates.
10. R. Freedman, L. C. Coombs, L. Bumpass, *Demography* 2, 267 (1965).
11. N. B. Ryder, in *Fertility and Family Planning: A World View*, S. J. Behrman, L. Corsa, R. Freedman, Eds. (Univ. of Michigan Press, Ann Arbor, 1969), pp. 99–123.
12. C. F. Westoff, E. G. Mishler, E. L. Kelly, *Amer. J. Sociol.* 62, 494 (1957). Additional evidence pointing to the same hypothesis appears in the Princeton Fertility Study (unpublished tabulations).
13. T. Frejka, *Population Stud.* 23, 394 (1969).
14. For discussion of the relationships between these variables see N. B. Ryder and C. F. Westoff, *Population Res.* (March 1969) and A. A. Campbell, *Fam. Planning Perspect.* 1, No. 2, 33 (1969).

15. We thank Ansley J. Coale, Ronald Freedman, Fred Jaffe, Suzanne Keller, and Norman B. Ryder for critical appraisals of the manuscript. We also acknowledge the able computer programming assistance of Andrea Smith.

A picture is presented of the distribution and concentration of the needs and services for family planning in the United States by county. Noteworthy is the concentration of the heaviest program inputs as well as the largest number of women not served in a relatively few urban counties.

GEOGRAPHIC DISTRIBUTION OF NEED FOR FAMILY PLANNING AND SUBSIDIZED SERVICES IN THE UNITED STATES

Raymond C. Lerner, Ph.D.

Introduction

A STUDY, *Need for Subsidized Family Planning Services: United States, Each State and County, 1968,* has recently been released by the Family Planning Office of the Office of Economic Opportunity. This paper will review the purpose and design of the study, and discuss findings which relate to the distribution of women at risk, the number reported served in subsidized programs, and the number unserved, by county, for the United States.

The object of this work was to collect, for each of the 3,072 counties in the U. S., basic data on the need for subsidized family planning services, the services currently available, selected characteristics relevant to need, and resources available for the delivery of services.

The purpose in compiling and collecting such data was, for the first time, to develop a capability for estimating the level of organized family planning services in the U. S. In addition, such information could assist in planning by making it possible to examine where program inputs were going and where they were needed. A file of this nature, it was felt, would also provide baseline data useful for monitoring improvements in the distribution of program efforts over time, and might also serve as a preliminary tool for evaluating the effectiveness of publicly financed family planning programs in reaching program objectives.

For each county in the U. S., selected variables on needs and resources have been compiled from existing sources; however, data on services required field surveys. This paper will deal with only a limited portion of the material on file; the items included in the study for each county are listed in the Appendix.

Methodology

The report, *Need for Subsidized Family Planning Services: United States, Each State and County, 1968,** includes

* Available from the Family Planning Program, Office of Health Affairs, Office of Economic Opportunity, Washington, D. C., or the Center for Family Planning Program Development of Planned Parenthood-World Population, New York, N. Y. 10022.

a full discussion of the methodology and the limitations of data. However, a few important points relevant to the material in this paper will be discussed here.

Population

The basic population denominator and number of women age 15-44 in this work consist of 1966 population estimates for the United States, by county, made by the State and Local Population Estimates Branch, Population Division, U S. Bureau of the Census.*

Need

The total number of women age 15-44 estimated to require subsidized family planning services consist of those who can be classified as medically indigent, fertile, exposed to risk of pregnancy, not currently pregnant or seeking a desired pregnancy. This has been approximated by applying the Dryfoos-Polgar-Varky formula to the census estimates for each county for 1966. The methodology employed by the formula, which was developed at Planned Parenthood, is described in detail in the full report.

Current Services

Because there were no readily available nationwide statistics giving patient figures from which to determine how many women were currently receiving family planning service from organized programs during the period from July 1, 1967, to June 30, 1968, three mail surveys had to be conducted.

We know that health departments, hospitals, and free-standing clinics are the major channels through which subsidized family planning services are delivered, but knowledge of the level of service and the exact locations of service facilities is severely limited. In order to establish a preliminary universe of agencies providing organized family planning services to low-income women, available data from previous reports and surveys were examined for each of these three channels. The field to be surveyed included voluntary and public hospitals, health departments, Planned Parenthood clinics, OEO family planning projects, Neighborhood Health Centers, maternity and infant care projects, and other agencies known to be providing family planning.

It was decided to survey hospitals, Planned Parenthood affiliates, and state health departments—individually and directly—to determine the number of patients served in their programs, and the addresses of their clinics. Responses originating from the same locality were compared for duplications, since combined funding and sponsorship sometimes result in duplicate reporting. When necessary, responses were also edited for conversion from visits to persons served since some agencies do not have record systems which enable them to report unduplicated counts of patients served. While the service figures are probably the best available nationally, they must be regarded as approximations.

No attempt was made to obtain figures on the number of women in the target population served by private physicians at their own expense or through Medicaid. Estimates based on scanty data place this proportion at less than 10 per cent of those in need. Nor could a study of this kind attempt to assess the retention rate of service programs or to evaluate their general quality. Therefore, while the term "number of women served" is employed, it would be more accurate to refer to the "number of patients enrolled" by an organized family planning service. How well or how fully the patients are served is not known, and it is probable that great variation exists from program to program. The study, therefore, could be

* Current Population Reports Series, p-25, Nos. 401, 404, 407 and 409, 1968, describe methodology.

regarded as estimating the extent to which organized programs have been successful in at least enrolling the population in need—a necessary first step toward the systematic evaluation of any program.

Within the defined universe of programs and agencies from which service data were sought, the response rate was excellent, nearly 100 per cent in all categories.

Findings

The data to be presented now are limited to distributions of need and services by county, along with a preliminary assessment of some general characteristics of the counties containing and not containing organized services.

Table 1 provides a summary of the distribution of U. S. counties by the number reporting organized family planning services in fiscal 1968.

In the U. S., it is estimated that, in FY 1968, there were approximately 5.4 million medically indigent women in need of subsidized family planning services. Among the 3,072 U. S. counties, only 1,200 reported organized programs, while, in 1,872 counties, no family planning programs for medically indigent women were identified. One hundred and twenty-two counties reported programs, but were not able to provide figures on the number of women served; they are included among the 1,200 counties with reported programs.

The 1,200 counties reporting organized family planning programs make up 39 per cent of U. S. counties; they also contain approximately 75 per cent of the total U. S. population, and of women aged 15-44, as well as the same proportion of low-income women in need of subsidized family planning services. Almost 800,000 women received subsidized services within these (1,200) counties, which amounts to about 15 per cent of all the women in the U. S. who are estimated to be in need of family planning services (Table 1a). At risk and remaining to be served in the counties with reported programs, were 3.2 million women, or 70 per cent of the total number of women who are unserved in the U. S.

While only 15 per cent of the women in need are being served nationally, there is, of course, great variation from county to county in the current service picture; a few counties were found to provide service to more than 40 per cent of the group at risk, while others reported less than 1 per cent. Among the 1,200 counties reporting services, 20 per cent of those at risk are being served. We still have a long way to go.

The 1,872 counties without reported programs constitute 61 per cent of all U. S. counties but they contain only about 25 per cent of the total U. S. population, about the same proportion of women age 15-44, and 1.4 million or 27 per cent of all low-income U. S. women at risk and in need of family planning. Since no programs are reported, unserved females also equal 1.4 million and unmet need equals 100 per cent.

In summary, about three-fifths of U. S. counties contain one-quarter of those at risk and report no organized programs; conversely, two-fifths of U. S. counties contain three-quarters of those at risk in the entire country and report service to about one-fifth of this group (Table 1). Since the two-fifths of U. S. counties with service contain roughly three-quarters of the U. S. population, it is obvious that these include most of the major urban areas in the country, where need is more highly concentrated. On the other hand, as noted earlier, the 1,872 counties with no organized programs contain only about 1.4 million women at risk, indicating that the need is much less concentrated in these counties.

Table 2 shows the distribution of counties ranked by quartiles of women

Table 1—Distribution of U. S. counties by number reporting organized family planning services for medically indigent women served and unserved: total U. S. population,[a] women age 15-44,[a] estimated number of women in need,[b] number of women served and unserved

	No. of counties	Total population[a] (1966 est.)	Female population[a] Age 15-44	Female population in need[b]	Females reported served	Unserved females
		(000)	(000)	(000)	(000)	(000)
U. S. counties reporting no organized family planning services to indigent women	1,872	48,888[c]	9,577	1,430	—	1,430
Counties reporting organized services to indigent women	1,200[d]	146,811	29,966	3,937	773	3,164
Total	3,072	195,699	39,543	5,367	773	4,594
			Vertical per cent			
No service	60.9	25.0	24.2	26.6	0.0	31.1
With service	39.1	75.0	75.8	73.4	100.0	68.9
Total	100.0	100.0	100.0	100.0	100.0	100.0
			Horizontal per cent			
	(000)					
No service	(N = 48,888)		19.6	2.9	0.0	2.9
With service	(N = 146,811)		20.4	2.7	0.5	2.2
Total	(N = 195,699)		20.2	2.7	0.4	2.3

a. U. S. Bureau of Census, 1966 population estimates.

b. Estimated by applying the Dryfoos-Polgar-Varky formula to female population age 15-44, 1966.

c. Rounding to the nearest thousand was done after computation.

d. One hundred twenty-two counties reporting service but not providing figures on the number of women served have been included; present information is that the number of women served in these counties is not significant.

Table 1a—Number of medically indigent women served and unserved as per cent of U. S. total estimated at risk for subsidized family planning services, fiscal 1968

	No.	%
Served	800	15.4
Unserved	4,600	84.6
Total need	5,400	100.0

served in the 1,200 counties with reported organized programs. The significant finding here is the concentration of service in relatively few counties: 8 counties, or 0.3 per cent of all U. S. counties, account for the first quartile in which about 200,000 women were served (or 25 per cent of reported services). Only 23 more counties, or 0.7 per cent of all U. S. counties, account for the next quartile—200,000 women served. Expressed cumulatively, *31 or only 1 per cent of all U. S. counties account for 50 per cent of all women reported served in subsidized family planning programs throughout the United States.*

Going one step further, the next quartile adds 86 counties. Thus, 117 counties, or 4 per cent of U. S. counties, account for 75 per cent of women reported served; that is, 600,000 out of 800,000 served throughout the U. S. This obviously reflects concentration of program inputs and, as will be shown later in more detail, those service areas include nearly all of the great urban counties where population is concentrated, where needs are most obvious, and where resources for delivery of services are most readily at hand..

Finally, the last quartile of women are served in 961 counties; these are for the most part quite small programs. On an average basis, there are about 200 women per county receiving service in the latter group of counties through all delivery agencies (although in most of these counties only one agency is usually providing services).

Table 3 shows the distribution of quartiles of unmet need: that is, the number of women estimated to be in need of subsidized family planning services but not reported as receiving them, and the number of counties in each quartile. There are approximately 4.6 million women still in need of service.

Table 2—Quartile range of women served in subsidized family planning programs for U. S., fiscal 1968; number and per cent of counties in each quartile

Women served			Counties			
No.	Cum	Cum %	No.	%	Cum	Cum %
(000)	(000)					
200	200	25	8	0.3	8	0.3
200	400	50	23	0.7	31	1.0
200	600	75	86	3.0	117	4.0
200	800	100	961	31.0	1,078	35.0
			122[a]	4.0	1,200	39.1
	None reported		1,872	61.0	3,072	100.0
			3,072	100 0		

a. One hundred twenty-two counties reporting service but not providing figures on the number of women served have been included.

Table 3—Quartile range of women estimated at risk for subsidized family planning services not receiving service for U. S., fiscal 1968, and number and per cent of counties in each quartile

Women unserved			Counties			
No.	Cum	Cum %	No.	%	Cum	Cum %
(000)	(000)					
1,150	1,150	25	69	2	69	2
1,150	2,300	50	244	8	313	10
1,150	3,450	75	626	20	939	31
1,150	4,600	100	2,133	69	3,072	100
			3,072	100		

Here, too, great concentration is evident: relatively few counties in the U. S., 69 in all, account for 25 per cent of the unmet need. The next quartile of unmet need involves 244 additional counties. Thus half of the unmet need of 2.3 million women is found in 313 counties (about 10 per cent of all counties).

It can be noted at this point that most counties with the greatest need figures are also found heading the list of counties with the largest program inputs. For example, if one compares the 50 counties with the greatest need to the first 50, by numbers served, 29 appear on both lists, indicating that there is fair correspondence between location of needs and service efforts. However, the magnitude of the input relative to need is as yet grossly insufficient, inasmuch as several million women remain to be reached and over one million of these are in relatively concentrated target areas in only 69 U. S. counties.

Table 3 shows that the fourth quartile of unmet need is spread over a vast area involving 2,133 counties. While these counties include some metropolitan areas, they are for the most part rural and rural-farm areas with small and dispersed populations and with few health resources, making it difficult and costly to reach the patient.

Table 4 expands on reported services as presented initially in Table 2. In Table 4, as in the earlier table, the number of women served is the controlling variable. The eight counties comprising the first quartile are detailed in Table 4 and vividly illustrate how service inputs have been concentrated in major urban areas. It was to show this that the county, state, and major city identifications were provided. Note that the East appears to be first with three New York City counties, Baltimore, and Washington, D. C. The Midwest is represented by Cook County (Chicago) and Wayne County (Detroit). Finally, in the Far West, we have Los Angeles County.

For proportion of those in need who are served, these areas represent fairly substantial program achievements when compared to the national average: in these eight counties 12 per cent were served—200,000 of 471,000 in need—whereas nationally only 15 per cent were served.

In the second quartile, involving 23 counties, 36 per cent of those at risk were served, in the third quartile 23 per cent, and in the fourth—the least densely populated counties of the U. S.—only 10 per cent. The column labeled "total population" illustrates the increasing dispersion as one moves from high to low

Table 4—U. S. counties by quartiles of women served in subsidized family planning programs; number of women served, estimated need, number unserved, female population age 15-44, total population*

No. of counties	Rank by no. served	County	State	Principal city	No. served (fiscal 1968)	Estimated need	Unserved	Females 15–44 (1966)	Total population (1966)
					(000)	(000)	(000)	(000)	(000)
Detailed listing of 8 counties comprising first quartile, with ranking by number served	1	Cook	Ill.	Chicago	38	82	44	1,029	5,400
	2	L. A.	Calif.	L. A.	33	126	94	1,375	6,814
	3	N. Y.	N. Y.	N. Y. C.	30	49	19	305	1,540
	4	Kings	N. Y.	N. Y. C.	22	64	42	548	2,702
	5	Wayne	Mich.	Detroit	21	59	39	532	2,705
	6	Bronx	N. Y.	N. Y. C.	19	36	17	314	1,543
	7	D. C.	—	Washington	18	21	2	164	806
	8	Baltimore	Md.	Baltimore	18	32	14	303	1,489
8	–	—	—	—	200	471	272	4,572	22,999
23	–	—	—	—	200	550	352	4,600	22,700
86	–	—	—	—	200	860	660	7,735	37,649
1,083[a]	–	—	—	—	200	2,080	1,880	13,059	63,463
1,872	–	—	—	—	No. services reported	1,430	1,430	9,577	48,888
3,072					800	5,367	4,594	39,543	195,699

* Rounding to nearest thousand performed after computation. Total computed in columns or horizontals may not tally due to rounding.

a. One hundred twenty-two reporting service but not providing figures on the number served have been included.

service areas. The first eight counties contain as many people as the next 23. The next 86 counties contain fewer people than the first two groups of 31 counties, and so on. The data make clear that the question of providing family planning services in those areas where population is spread thin has only begun to be examined. Indeed, this is generally true for nearly all health services, not merely family planning.

Table 5 presents data on the population size and the range of the percentage of rural-farm population in the 1,200 counties reporting service figures, arranged again by quartiles of women served. It can be seen from the range of population size that, while in general the counties with least service in the fourth quartile must include many sparsely populated areas, they are not exclusively so. One county in this quartile contains 1.3 million people—suggesting that even in large urban areas the extent of programing for family planning services is severely deficient.

It appears that the first two quartiles, accounting for half of the women served, are comprised exclusively of high-population counties. For example, in quartile two the smallest county by population size is 320,000. Very few of these 31 counties in the first quartiles have any rural-farm population.

The third quartile contains counties that range from relatively small—25,000 population—up to quite large—1.4 million—and show a wide variation in percentage of rural-farm population.

In the fourth quartile, there is a tremendous range, both of population size—from less than 1,000 to 1.3 million—and of rurality—from zero to 59.5 per cent (an inordinately high proportion to be classified as rural-farm). These 1,083 counties are a great mixture of county types, including some highly urban areas which are in fact part of great metropolitan centers (i.e., Boston, Massachusetts; Passaic, New Jersey; Suffolk County, New York) as well as some of the most rural parts of the United States.

It is obviously not always possible to categorize counties as urban or rural-farm areas. The usual problems of classification plague the researcher on this as on so many other dimensions. For, within a single county, there may be extensive urban as well as rural-farm areas. The socioeconomic ecology of a region does not usually oblige us by observing county jurisdictional lines. This factor often results in the mixture of characteristics demonstrated in the tables. Table 6 provides an overview of the number of women unserved with respect to the rural-farm characteristics. All U. S. counties have been ranked from low to high according to per cent rural-farm, and then distributed by quarters by the number of women needing subsidized family planning service. In addition, the number of counties for each quarter with no reported programs are shown.

The 124 least rural counties contain a

Table 5—Quartile range of women served in subsidized family planning programs for U. S., fiscal 1968; for each quartile: the number of counties, range of population size, and range of per cent rural-farm population

Women served	No. of[a] counties	Range of[b] population size	% rural-farm[c]
(000)		(000)	
200	8	800–6,800	All less than 1
200	23	320–2,000	0.0– 2.4
200	86	25–1,400	0.0–17.5
200	1,083[a]	<1–1,300	0.0–59.5
800	1,200		

a. One hundred twenty-two counties reporting service but not providing figures on the number of women served have been included.

b. Bureau of Census estimate for 1966.

c. 1960 Census.

Table 6—All U. S. counties ranked by per cent rural-farm population and distributed by quarters of women unserved (fiscal 1968), range of per cent rural-farm poputation per quarter, number and per cent of counties, and number and per cent of counties with no program

Range % rural-farm population[a]	No. of women unserved	No. of U. S. counties	% of U. S. counties	Counties with no subsidized programs		
				Nr	%	
	(000)					
0.0– 0.9	1,150	124	4.0	26	21.0	(N=124)
1.0– 5.2	1,150	359	11.7	45	12.5	(N=359)
5.3–17.8	1,150	876	28.5	500	57.1	(N=876)
17.9–86.0	1,150	1,713	55.8	1,301	75.9	(N=1,713)
	4,600	3,072	100.0	1,872	60.9	(N=3,072)

a. 1960 Census.

quarter of the number of women needing service (1.15 million). No county within this group exceeds 0.9 per cent of rural-farm population; and only 26 or one-fifth of these counties report no program. In the next group, all counties show a small proportion of rural-farm population, not less than 1 per cent and not more than 5 per cent. Here also a small number of counties, about one-eighth, report no program.

Group three moves into the middle to upper range with respect to rurality, and this includes 28.5 per cent of all U. S. counties; 500 or 57 per cent of these report no programs. Finally, in group four, we are really in the country. These are predominately rural counties and include over half of all counties in the U. S. Seventy-five per cent of these counties report no program. As rurality increases, programing decreases.

Table 7 illustrates the program potential of 1,872 counties with no reported service. In this table, the distribution of all counties with no service is

Table 7—Number and per cent of U. S. counties with no subsidized family planning services, by range of estimated number of women in need; number and per cent of women unserved

Counties with no service				Range, estimated no. of women needing service	No. unserved	Cum	%	Cum %
No.	Cum	%	Cum %					
					(000)	(000)		
123	123	6.6	6.6	2,000–10,000	382	382	26.7	26.7
315	438	16.9	23.5	1,000– 1,999	428	810	29.0	55.7
558	996	29.7	53.2	500– 999	395	1,195	27.8	83.5
876	1,872	46.8	100.0	000– 499	235	1,430	16.5	100.0
1,872		100.0			1,430		100.0	

controlled by the range of estimated number of women in need. The total number of women in need is also presented for each group of counties.

Line two in the table shows that a total of 438, or 24 per cent of counties with no program, contain 1,000 or more women at risk; cumulatively, these counties contain a total of 819,000, or 56 per cent, of all those unserved in counties without programs. They should be regarded as areas with high program potential since they contain 1,000 or more women at risk.

The figure of 1,000 or more women per county at risk and in need is a useful measure of the service potential in these areas, since it is estimated that this number of patients is sufficient to provide minimum economy of scale in the operation of a clinic program.

The remaining two groups, totaling three-quarters of all U. S. counties without programs, are the more sparsely populated ones and account for 44 per cent of women at risk in unserved areas.

Summary

This paper has presented in broad terms the distribution and concentration of needs and services in the United States by county.

Of particular note is the concentration in relatively few urban counties of both the heaviest program inputs as well as the greatest number of women unserved. Equally important, a program potential exists in 438 counties with no service provided and more than 1,000 women at risk.

The data also point up the virtual nonexistence of *organized* programs in sparsely populated and rural-farm areas of the United States. In qualitative human terms, the need for family planning programs here is undoubtedly just as great as in metropolitan communities.

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APPENDIX

What Is in the File—for Each County in the United States.

a. *Needs and Services*

Total population of U. S., 1966; women in the childbearing years, i.e., 15-44; number of women medically indigent needing subsidized family planning services; number receiving family planning services through subsidized clinic programs; number in need not receiving services, or unmet need; number of home-based migrant workers; number of American Indians under the jurisdiction of the Indian Health Service of DHEW.

Under needs we have also selected health and demographic indexes which provide greater insight into the characteristics of each county: infant mortality rate; number of infant deaths in excess of 17.8 per 1,000 for the five years 1961-1965; fertility rate per 1,000; live birth order as a per cent of all births; out-of-wedlock births per 1,000 live births (not reported for 16 states); births of 2,500 grams or less as a per cent of live births.

Each county is classified by whether it is within a Standard Metropolitan Statistical Area or State Economic Area (for New England) or a nonmetropolitan county according to total population of SMSA, SEA or county.

b. *Resources*

Physicians—Number of nonfederal physicians in patient care with offices in the county; ratio of M.D.'s per 100,000 population; num-

ber of general practitioners; ratio per 100,000 population; number of obstetrician-gynecologists and ratio per 100,000 population.

Hospitals—For all short-term, general-care, nonprofit hospitals reporting births, operated by private agencies, nonfederal governmental agencies, but including the Public Health Service and Indian Health Service hospitals: number in each county; total births reported for all hospitals in the county; number reporting family planning services.

Other Resources — Counties with medical schools; community action agencies; OEO-funded Family Planning Projects; OEO-funded Neighborhood Health Centers; counties with Model City Programs; Children's Bureau Maternal and Infant Care Projects; Public Health Service Neighborhood Service Projects; counties where the health department provides family planning services; and finally, counties where Planned Parenthood affiliates provide family planning services.

To what extent can greater accessibility to abortion services affect poverty and its problems? This analysis addresses itself to such questions and develops proposals for identifying the socioeconomic impact of liberalized abortion laws and accessible services.

SOCIOECONOMIC OUTCOMES OF RESTRICTED ACCESS TO ABORTION

Charlotte Muller, Ph.D., F.A.P.H.A.

THE recent changes in the legality of abortion in the United States through repeal, reform and court action, and the various court cases and legislative movements in the current news, have changed the nature of the problem of access to a large degree. Once chiefly a matter of leveling legal barriers, the access problem now relates to financing, referral, organization of appropriate facilities for care, and patient factors influencing utilization in different social and age groups. The implications of restricted access to care, the subject of the present paper, apply, for different reasons, to post-repeal states (Alaska, Hawaii, New York and Washington), to reform ("health and life"*) states such as California, and to states with old-style laws, which still constitute the majority.

The small market for legal abortions in states with old-style laws has been restricted in access to a certain number of women of means who are able to procure private medical and psychiatric care[8] in hospitals amenities. Meanwhile, their less affluent sisters have rarely been able to receive medically equivalent care in the wards of public hospitals and as service patients in voluntary hospitals. These facts have been well-documented by Hall for hospitals in New York City, New York State, and the United States in reports showing ward/private differences in the ratio of abortions to deliveries, and similar differences between public and other hospitals.[5,6]

The far larger market for illegal abortions (and now, for out-of-state legal abortions) has also been class-structured in that it was the non-poor candidate who could afford jet travel to a service area or the attentions of a qualified physician, although without hospital protections or amenities, in an illegal abortion. The poor candidate was more likely to end up in the hands of the non-medical practitioner or to substitute crude attempts at self-induced abortion through chemical and physical means.

Imperfection in the market inheres in uneven access to knowledge of sources of supply as well as in uneven access to suppliers for economic, social class, and geographical reasons. The result of market imperfections including legal constraints on entry is a lessening of consumer welfare, and in particular, a restriction on the option of couples to choose a fertility level consistent with their total set of preferences for leisure, material goods, the company of children,

* With account taken of present and future environment in determining the risk to health in Oregon's law.

and the educational package they consider normal for each produced child.[2]

Unlike some other health services, the improved accessibility of abortion (which for the poor is a matter of present concern) is evidently a service whose utilization greatly rises in the event of legal accessibility. This is shown by the experience of countries which have passed laws broadening the grounds for abortion to include health as well as life of the mother and admitting socioeconomic considerations. It is also shown in states like California and Colorado which have liberalized the law.[1] A more advanced law in Great Britain was followed by a shift in performance of abortions from private auspices to National Health Service financing, as well as an over-all rise.[16] With wider legal access, the seeking of inferior substitutes, including attempts at self-induced abortion, will doubtless decline, with direct improvement in the maternal death rate among black and Puerto Rican women.[4] It is not clear that all latent demand would be satisfied: some women are held back by the lack of privacy of official procedures, and review committees as in states where "health and life" are accepted grounds; some physicians would continue to refuse to perform the operations; and, some women would deny the reality of the pregnancy until late in its course as they now do. The price of the service would still be a factor in utilization, although it is not easy to say just how elastic the demand is where the legal barrier exists.

Barriers to legal abortion affect the ratio of unwanted children born. Low-income couples express the same family-size goals as higher income couples,[7a] but are less successful, on the whole, in the use of contraception. The leverage power of abortion in adapting actual to desired family size is thus of relatively greater importance for low-income groups.

However, it is necessary to have a limited expectation of the extent to which, based on the foregoing, reduction in unwanted births will solve poverty problems. So long as poor couples desire 3 or 4 children—or more—available means of birth prevention would not necessarily be used to control family size and per capita income would remain low. And, independent of family size among the poor, the reduction of poverty requires a variety of specific programs to deal with low job skills, deficient labor market organization, family health needs, and income maintenance problems, to cite a few items on the national agenda.

The negative effect of unwanted births on family economic and social welfare is felt by way of defects in the timing of the first birth, defects in spacing the interval between children, which affects family capacity to accept the new child, and defects in terminating family formation. Although the reduction of welfare is really the joint result of limitations of the present arrangements for birth control (deficient access, failure to utilize and imperfections in method) and of restricted access to abortion, it is nevertheless possible to avert negative outcomes by better availability of abortion alone, and this is especially true, for the reason cited above, for low-income groups.

One of the important situations relates to the separation of the teen-age male from the educational process.

Alvin Schorr has beautifully presented the mechanism and the evidence linking the family cycle and economic life. Early marriage is generally forced marriage, the result of premature pregnancy. The young father leaves school and cannot return. His bargaining power in the job market is poor and his first job choices are in low-opportunity situations as a result of immediate necessity, lack of information, and low skill. He may also fail to find work. The marriage of the young is less stable, statistically

speaking, than that of a later age, but the probability of a large family is also associated with early age of marriage. Whether the family is separated or united, the burden of support prevents the young adult from experimenting with various types of work. And the family fails to accumulate capital for any decisive improvement in circumstances such as additional training.

Statistical support for this model includes:

1. The high per cent of premarital pregnancy in school-age marriage (one-third of all school age marriages, 87% where both spouses were high school students).

2. The larger family size for both white and black mothers who marry at 18 compared with 2 or 3 years later (white, 3.7 compared with 2.8 children; black, 4.3 compared with 4.0 children). This comparison also reveals the limited success of black families at birth control, with age of marriage having less effect on family size than among whites.

3. The occupational distribution of teen-age males compared with older workers.[15]

In 1966 there were 1.2 million young males aged 16 to 21 who were school dropouts and members of the labor force. Sixty-one per cent of them worked as operatives and non-farm laborers.[21a] (This number rose to 1.6 million in 1969.)[21b]

The crucial outcome in terms of the economic history of the teen-age male is the reduced lifetime earnings of a man who has not completed high school, and again the greater earnings of the college graduate compared to the high school graduate.* Differences also show up in a cross-section. Let us compare just two educational levels within white and black groups. Money income figures for 1968 by years of school completed show 5.9 million white family heads who are college graduates with median income of $13,589, and 7.1 million who started but did not finish high school with median income of $8,525. In non-white families, where the head finished college, the family income was $12,472 (267,000 families); where he started but did not finish high school (1.0 million families), the median income was only $5,766.[21c]

The ratios implicit in the above income figures would be altered with changes in the relative supply of males at the different educational levels, and are also influenced by the structure of demand for workers at different levels. But the return on human capital added by educational processing is real, and it is estimated that four-fifths of high school dropouts are intellectually capable of additional education.[20]

Another problem for economic improvement in the family concerns job-seeking by the mature woman with children. The crucial statistic is that median family income (1968) is 30 per cent higher for families with a male head when the wife is in the paid labor force than when she is not.[21d] The presence of children under six is a deterrent to labor force participation.[22] It is true that an untrained woman may not add greatly to family resources by her employment. What this implies, perhaps, is that training programs are needed to capitalize on the economic opportunity presented to the family by the mother's freedom from pregnancy. It also calls attention to the compulsory school-leaving for girls consequent on pregnancy in many communities, a factor which adds to the effect on long-run family earning potential described above for teen-age males. Girls who started their families in their teens, in their maturity make up a portion of the group

* Data for 1968 estimate lifetime incomes for males 25 years and over by years of schooling: 1-3 years of high school, $294,000; 4 years of high school, $350,000; 4 or more years of college, $586,000. (*Statistical Abstract of the United States*, 1970, p. 111.)

of untrained women. Finally, for married women, mothers of young children, who must work out of financial necessity—18 per cent of those who took jobs in 1963 did so for this reason[24]—unsatisfactory arrangements for child care represent a family price that is paid for their labor force participation and a possible source of fluctuating availability for work. To a considerable degree this is also true for middle-class women who wish to work for personal satisfaction and extra income.

Like the married woman returning to the labor market, the young widow is available for employment to an extent dictated by the age of her youngest child and the number of her children. Half of widowed mothers with 3 or more children did not work at all in 1962, compared with 28 per cent with only one child, and the former group tended to work part-time, if at all. Since part-time employment is in lower-paying occupations, earning power was doubly affected. Furthermore, employment and earnings after termination of child care benefits under Social Security are found to be greatly affected by work experience in the preceding 5 years. Hence, the economic potential of young widows is greatly influenced by size and spacing of families.[25]

A third economic problem exacerbated by uncontrolled family size is present poverty. According to Mollie Orshansky,

> "The family with 5 or more children was still (in 1966) 3½ times as likely to be poor as the family raising only one or two, and . . . almost half the poor children were in families with 5 or more children."[12a]

She further points out that large family size (4 or more children) was found in an increasing number of poor families where the head was a fully employed worker (37% in 1965).[12b] How poor is poor? The median income of a poor family with male head in 1966 was $3,308 for a 4-child family, $3,590 for a 5-child family, and $3,410 for a family of 6 or more children.[12c]

About one-fourth of poor families, and about one-fifth of near-poor families, had 4 or more children[12d]—or 2,214,000 out of 15,240,000 families in the poor and near-poor categories.

The family income figures for the large poor family are equivalent to per capita income of $552, $513, and $430 (or less) respectively. In sharp contrast the lowest budget standard for a 4-person urban family, as priced by the Bureau of Labor Statistics in 1967, was $5,915 or $1,479 per capita.[23]

The immediate consequence of spreading fixed family resources over more persons is fewer goods and services per capita. Transfer payments received by about one-fourth of the poor (assistance, Social Security payments, veterans' pensions, and other devices to transfer current national income between persons by the tax-spending mechanism) are already counted in current income. Even with public assistance the large poor family could not hope to consume at anywhere near the lowest budget standard of the BLS.

Children who lack a welcoming and nurturing parental home can be counted along a continuum of extrusion from the family of origin. The continuum includes adoption, foster home placement, court action for neglect and dependency and less severe but indifferent or otherwise unsatisfactory parental role performance within the family of origin. To count numbers involved is to become cognizant of the numbers of children affected by various degrees and causes of being unwanted during childhood, although one cannot infer that the child was unwanted during the pregnancy. The program costs involved, as in foster or institutional care, must be reduced by the amount of the maintenance component, which would be incurred (although not necessarily at the same level), regardless of where a child is

raised. However, program costs would be higher if services such as schooling for pregnant girls were more adequate.

One measure of children with a problem related to their birth is out-of-wedlock births. The number in 1967 was 318,072, with the figure expected to reach 403,000 by 1980 without any increase in rate. (The rate was 24 births per 1,000 unmarried women ages 15–44 in 1967.) Forty-seven per cent of these births are to girls under 20 years of age.[11] Illegitimate births were 9.7 per cent of total live births in 1966.[21e] Occasionally, out-of-wedlock births are not unwanted, and some are followed by marriage.[14] If this indicates that the figure overstates the problem, it should be remembered that many births in married women are undesired as well as unplanned. One even finds children placed for adoption with both parents living and together. Both in this group and in children retained in the family origin are children born after pregnancy has been followed by marriage.

Another aggregate cited is the number of children given for adoption. This group numbered 158,000 in 1967, or 82.3 per 10,000 children under 5,[21f] but only two-thirds of these were out-of-wedlock births.[18] Extra-legal but permanent adoptions add to these figures.

Many children are not adoptable because of defect or retention of parental rights by incompetent parents or for reasons of racial or religious prejudice. Yet adoptions certainly provide a minimum estimate for the occurrence of preventable births.

The unwanted child is not necessarily indicated by birth order. A wealthy family can provide for a fourth or fifth child materially, and with personal care. A poor family, or one where the mother has a health impairment, may not be able to welcome a third child. Nevertheless birth order, especially in conjunction with income level, is a useful measure of the problem of preventable births. Orshansky's figures yield a count of at least 2.2 million fourth children in birth order among the poor and near-poor, 1.3 million fifth children, and .7 million sixth children.[12e] These figures may be compared with average family size preferences of 2.9 children for non-whites and 3.3 for whites.

It may be pointed out here that in a study of cases of severe parental neglect, the average family size was 8 people. The neglectful family was cited as having inadequate diet, irregular meals and poor food preparation; lack of cleanliness, absence of routine; and neglect of medical problems. Apathy was the predominant attitude. There was a lack of internal and external means for building a positive life-style. The children were often having trouble in school.[30]

The possibility of identifying unwanted children by comparing family-size goals with family size achieved depends on the time at which desired family size is ascertained, since people adapt their announced goals in the event of pregnancy (and a portion of them even succeed in adapting their attitudes and behavior).[3] Conversely, a child originally desired may become unwanted because of the likelihood of deformity, the death or disability of a parent, income change—or the breakup of the marriage. (This change in status of the child has a bearing on the question of abortion only insofar as the change occurs soon after conception.)

If correct, this comparison is a powerful measure. It reveals between 750,000 and 1,000,000 excess births a year between 1960 and 1965. These figures are based on a re-analysis of 1965 national survey data by Charles F. Westoff. The lower estimate is based on births unwanted by both parents, and the higher, on births unwanted by at least one parent. If one uses the higher estimate, 445,000 births among the poor and near-poor are classed as excess, or 42 per cent of all their births, compared with

17 per cent among the non-poor. The incidence of unwanted births increases rapidly with birth order. The estimates cited are minimal in that births retrospectively rationalized by the parents, and births representing timing failures, are omitted.[32]

Children born and living their early years under psychological rejection by mothers, social abandonment by fathers, poverty and other disadvantaged conditions, are exposed to risk of impaired development which, regardless of all other consequences, is economically important as a cause of inferior earning power at maturity. In the several aspects of this problem to be discussed, it is suggested that it is chiefly impaired educational chances which threaten future economic potential. Let us look first at mental retardation.

Seeking of prenatal care late in pregnancy, and inadequate nutrition, are typical or frequent in unwanted pregnancies. At least for high-risk mothers, late care and nutritive lacks are a factor in complications and prematurity, which in turn are found to be related to impaired learning potential. Pasamanick has pointed out that very young mothers and older women had a higher risk of producing mentally defective children, and increasing birth order also increased the risk.[13a] It has also been noted that the extra medical risks of pregnancy among the very young are complicated by the unmarried status and poverty of the adolescent girl typically involved.[17]

Although the status of being unwanted does not predict a certain incidence of mental retardation, in the sense of being either a necessary or a sufficient cause, it is pertinent that of the many births among the poor, who are exposed to the hazards which may lead to mental retardation, a large per cent appear to be unwanted.

Since mental retardation is a multi-caused phenomenon in which the nurture, educational stimulation and social opportunities of the child affect outcome, it is surmised that a mild handicap (the more typical case) is continually reinforced in the large, poor, culturally isolated family.

Furthermore, once adolescence is reached, access to higher education and to jobs with responsibility for large assets is dependent on being in the upper track of learners. The chance to increase earning power either by adding to human capital or by associating with expensive cooperating factors of production is impaired by mild mental retardation.

General mental health of the infant is said to be affected by the same considerations of the prenatal environment as applied to development of learning capacity. Pasamanick mentions 5 clinical entities in children significantly associated with complications of pregnancy and prematurity: cerebral palsy, epilepsy, mental deficiency, behavior disorders and reading disabilities.[13b] "Cases" differ from controls not in operative procedures or in long and difficult labor, but in long toxemias and bleeding —i.e., in medical rather than obstetrical features. Summing up, Pasamanick states:

> "There exists a continuum of reproductive insult, at least partially socio-economically determined, resulting in a continuum of reproductive casualty extending from death through varying degrees of neuropsychiatric disability."[13c]

Acceptance by and interaction with parents continues to be an influential factor in the course of mental health throughout childhood.[10,27]

In a study of cases of children requiring agency foster care in New York City, 10 per cent of initial placements were due to severe neglect or abuse and 33 per cent to family problems including rejection milder than the preceding category.[9] An annual figure of 154,000, 2.1 per 1,000 children, for juvenile court

cases of dependency or neglect, in jurisdictions covering two-thirds of the population under 18, is said to be an understatement of the incidence of this problem.[19a]

Impaired mental health interferes with the formal educational process (for example, when there is a behavior problem in the classroom) and with socialization of the child so that he can perform in the labor market at the maximum level for his capacities. At the extreme, delinquency and punishment or other social response removes him from the conventional developmental sequence. It is noted that delinquents often come from broken homes or have many brothers and sisters. A correlation is also noted between adolescent misbehavior and the absence of the father or limited opportunity to identify with him.[28a] (We note about 700,000 children in juvenile delinquency cases in 1967, or 2.3 per cent of those between 10 and 17 years, and an upward trend in rate.)[19b]

Educational growth of the child is recognized to be handicapped in the large family where income and parental time are inadequate. (Income is a substitute for time as when the mother reads to the four-year-old while a sitter walks the baby, or when the four-year-old is sent to a private nursery school while the mother tends the baby.) This problem is broader than the case of actual retardation or diagnosed mental illness in a child.[28b]

Finally, the large poor family is less likely to secure medical attention for its children.[26] The number of school days lost because of illness is greater than for higher income groups.[25] Nutritional defects add to time of recovery after infection and are related to days of school missed. Continuous school attendance has significance for development of human capital.

Summary

It is difficult to assign a weight to the importance of births in excess of desired family size, or births ill-timed in terms of family welfare, in the creation of social problems of neglect, delinquency, psychological and social incapacity to care for children, and the like. Nor is it easy to isolate the effects of this factor on the set of job *vs.* education choices made by the young father, the difficulties faced by the mature woman in planning re-entry to the labor market, and the experience of being a youthful consumer at the poverty-level of income. Equally, the underdevelopment of human capital by reason of mental retardation, physical and psychiatric health problems, and educational undernourishment defies exact division among specific causes. However well research methods for dealing with multi-caused phenomena succeed in elucidating these relationships in the future, there is in any event food for thought in the present. Ability to control family-size, including the right to abortion, must essentially seek approval on its merits. Personal freedom, equal access to care, and medical protection of the poor are all involved. Yet the discussion cannot help being influenced by observed associations between unplanned births and poverty, untimely marriage, and creation of stress on parental capacities of the more vulnerable for whatever reason.

Future Research

The design of relevant research concerning access to, and financing of, abortion services calls for flexibility because of the fluid situation which now exists with respect to law and policy. If realistic, such research can be useful in guiding policy choices.

1. *Financial needs of patient groups* can be identified by studying total service costs under different marital, social, racial and medical-clinical situations of the patient. Women who have had illegal abortions appear to be more willing than it was previously assumed to reveal information bearing on incidence, preva-

lence, and attendant circumstances.[31] Legality should improve the information flow. This may make it possible to develop estimates for direct costs for medical care and associated travel, and for the indirect costs of lost work-time and child-care replacement, both on a per case basis, and for aggregates. The present cost of surgery, hospital days, and pregnancy tests, determined by familiar methods of medical care research, can serve as a guide to the program expenditures that would be necessary to assure economic access for the low-income woman as state laws yield to the reform movement.

2. Systematic observation of the medical and behavioral *effects of non-hospital service programs*, and of the use of manpower and facility space resources which they entail, could be carried out as such programs are mounted. Such study will aid in developing and revising standards for a non-hospital service.

3. Understanding of one and two is essential for the design of an adequate prepayment benefit; this task needs to be supported by *continuing surveillance of present coverage and gaps*. Insurance entitlements for maternity in the private sector vary widely by employment group and carrier.[33] Nevertheless, a knowledge of current practice as to waiting periods, in-hospital care requirements, payment schedule limits, and family contract conditions is needed for policy purposes. Public sector entitlements have their own sources of geographical and program variation within military dependents, welfare and OEO medical care programs.

4. Finally, *manpower needs* are crucial in view of previous unmet demand. The assessment of additional training required to prepare practicing physicians and medical students to participate in the provision of abortion service is one task, and the appraisal of the attitude of professionals focuses on an element as important as numbers with requisite preparation. The possible role of paraprofessionals in a related theme for health manpower research. This is especially interesting, because in creation of a service able to handle a mass demand, traditional guild issues may be somewhat subdued.

States which have liberalized their abortion laws constitute a natural laboratory for the trial of new approaches in regard to financing, organization, manpower, and referral. Although little advantage has yet been taken of this fact, evaluation of early experience should be encouraged to aid in the development of appropriate social mechanisms for service.

REFERENCES

1. Frank J. Ayd, Jr., "Liberal Abortion Laws," America, February 1, 1969, p. 131; E. W. Overstreet, "Logistic Problems of Legal Abortion," AJPH, 61:3, March, 1971, p. 496.
2. Richard A. Easterlin, "Towards a Socio-economic Theory of Fertility: Survey of Recent Research on Economic Factors in American Fertility," in Fertility and Family Planning, edited by S. J. Behrman, Leslie Corsa, Jr., Ronald Freedman, Ann Arbor, 1969, pp. 134–135.
3. "Economic Status, Unemployment, and Family Growth," Social Security Bulletin, May, 1966, p. 39.
4. Edwin M. Gold *et al.*, "Therapeutic Abortion in New York City: a 20-Year Review," American Journal of Public Health, July, 1965.
5. Robert E. Hall, "Present Abortion Practices in Hospitals of New York State," New York Medicine, vol. XXIII, No. 4, pp. 124–126, March, 1967.
6. Robert E. Hall, "Therapeutic Abortion, Sterilization, and Conception," American Journal of Obstetrics and Gynecology, vol. 91, No. 4, pp. 518–532, February 15, 1965.
7. Frederick S. Jaffe and Alan F. Guttmacher, "Family Planning Programs in the United States," Reprinted from Demography, vol. 5, No. 2, 1968, a, p. 1 (citing Freedman, Whelpton and Bogue Studies), b, pp. 3, 9.
8. See JAMA, January 16, 1967, vol. 199 No. 3, Editorial, "Abortion and the Law" on use of psychiatric grounds for therapeutic abortion.
9. Shirley Jenkins and Mignon Sauber, Paths to Child Placement, New York City Department of Welfare and The Community

Council of Greater New York, 1966, pp. 9, 24.
10. Robert M. Mulford, "Emotional Neglect of Children: A Challenge to Protective Services," Child Welfare, October, 1958, p. 20.
11. National Council on Illegitimacy, "Comments on Recent Trends in Illegitimacy in the U. S.", June 13, 1969.
12. Mollie Orshansky, "The Shape of Poverty in 1966," Social Security Bulletin, March, 1968, a. p. 9, b. p. 11, c. p. 20, d. p. 7, e. Table 4.
13. Benjamin Pasamanick, "Epidemiological Investigations of Some Prenatal Factors in the Production of Neuropsychiatric Disorders," in Health and the Community, Alfred H. Katz and Jean S. Felton, Editors, New York, 1965, a. p. 204, b. p. 203, c. p. 211.
14. Mignon Sauber and Elaine Rubenstein, Experiences of the Unwed Mother as a Parent, Community Council of Greater New York, 1965, pp. 152-153.
15. Alvin L. Schorr, "The Family Cycle and Income Development," Social Security Bulletin, February, 1966.
16. Christopher Tietze, "Legal Abortion in Industrialized Countries," presented in Pakistan, January 28-February 4, 1969, p. 15.
17. U. S. Children's Bureau, Childbearing in and Before the Years of Adolescence, reprinted 1967, pp. 3, 10.
18. U. S. Children's Bureau, Statistical Series 92, Supplement to Child Welfare Statistics—1967, Adoptions in 1967 (1968), pp. 1, 11.
19. U. S. Children's Bureau, Statistical Series 93, Juvenile Court Statistics 1967 (1969), pp. 1, 6, a. pp. 1, 6, b. p. 1.
20. U. S. Children's Bureau Publication No. 460, The Nation's Youth, A Chart Book, 1968, Chart 28, text.
21. U. S. Department of Commerce, Statistical Abstract of the United States, a. (1968) p. 111, b. (1970) p. 113, c. (1970) p. 325, d. (1970) p. 324, e. (1970) p. 50, f. (1968) p. 10.
22. U. S. Department of Commerce, United States Census of Population 1960 Labor Reserve, PC (2) 6C, 1966, Table 14.
23. U. S. Department of Labor, 3 Standards of Living for an Urban Family of Four Persons, Spring, 1967, Bulletin No. 1570-5, 1969 p. 6.
24. U. S. Department of Labor, Special Labor Force Report No. 59, Why Women Start and Stop Working: A Study in Mobility, September, 1965 (from Monthly Labor Review, Reprint No. 2476), p. 1078.
25. U. S. National Center for Health Statistics, Series 10 No. 47, Disability Days United States—July 1965-June 1966, October, 1968), p. 7.
26. U. S. National Center for Health Statistics, Series 10 No. 49, Volume of Physician Visits United States--July 1966-June 1967, (November, 1968), p. 6.
27. U.S., NIMH, National Clearinghouse for Mental Health Information, Mental Health Program Reports No. 1, February 1967, pp. 255 65, "Studying the Infant-Mother Relation-ship for Clues to the Causes of Aberrant Development," Nahman H. Greenberg, M.D.
28. U.S., NIMH, The Mental Health of Urban America, PHS Pub. No. 1906, April, 1969, a. pp. 17, 32, b. p. 12.
29. U. S. Social Security Administration, Research and Statistics Note No. 15—1969, Some Facts About the Employment of Widowed Mothers, August 20, 1969.
30. L. R. Young, "An Interim Report on an Experimental Program of Protective Service," Child Welfare, July, 1966, pp. 371-377.
31. Nancy Howell Lee, Acquaintance Networks in the Social Structure of Abortion, Harvard University, 1967.
32. Charles F. Westoff, "The Extent of Unwanted Fertility in the U.S.," presented at Planned Parenthood-World Federation, October 28, 1969.
33. C. Muller, "Health Insurance for Abortion Costs: A Survey," *Family Planning Perspective*, 2(3, October, 1970.

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Item No. 45

One Hundred and Twenty Children Born After Application for Therapeutic Abortion Refused

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INTRODUCTION

The aim of the present study was to determine the mental health, social adjustment and educational level of children born after their mothers had applied for legal abortion on psychiatric grounds, and been refused. For this purpose we compared a series of children born of these pregnancies with an equally large control series, following all the subjects up to their 21st birthday.

Therapeutic abortion was first officially legalized in Sweden in 1939 and during the years of relevance to this study it was permissible on the following grounds (which are still valid):

When, because of disease, physical defect or weakness in the woman, the birth of the child would endanger her life or health.

When the pregnancy is the result of a felony, such as rape or incest, or intercourse with a girl under 15, or of the woman being made to submit to intercourse against her will because of being dependent on the man, or when it is any other way the result of gross violation of the woman's freedom of action.

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When the expected child might inherit a mental disease, mental deficiency, or a severe physical disease or deformity, either from its mother or father.

On July 1, 1946, the law was broadened to include the following indication:

When, in view of the woman's living conditions or other circumstances, it can be assumed that the birth and care of the expected child will seriously undermine her mental or physical health.

This indication came too late for the mothers of the present subjects. It has led to much debate in Sweden, but the psychiatrists at our hospitals seem to have based their recommendations for or against abortion on essentially the same grounds before 1946 as they did afterwards.

Much has been written about abortion during recent years. Among Swedish studies are: *Lindberg's* (1948) What does the woman do when the psychiatrist says no to her application for abortion?; the social worker *Karin Malmfors'* (1951) follow-up study of 200 women who had applied for abortion; *Ekblad's* follow-up study (1955) of 479 women granted an abortion on psychiatric indications; *Arén & Åmark's* (1957) study of the outcome in 244 cases of authorized but unperformed abortions; *Arén's* (1958) study of 100 newly delivered mothers who had a former pregnancy prematurely terminated on legal grounds; *Kerstin Höök's* (1963) follow-up study of 249 women refused a legal abortion. *Schlaug* (1952) studied the male partner in 488 cases of application for abortion. *Ekblad's* and *Hook's* publications also contained data on the men concerned.

Thus several studies have been made of the mothers and fathers involved in cases of abortion. But little has been written about the third member of the trio involved—the unwanted child. *Arén & Åmark* (1957) related that 12 out of 162 children born to women who had gone through with their pregnancy were sent to a foster home for permanent care or adoption. *Malmfors* (1951) related that 7 out of 85 children born after an application for abortion had been refused were left for adoption. These authors said nothing more about the fate of these children, and *Arén & Åmark* did not check their information in the official registers. Furthermore, both these studies were made between 3 and 5 years after the children were born, when they were too young to permit any conclusion about their mental health or social adjustment. *Höök* (1963) followed a number of features in 204 children in her series

until they were 8 1/2 years old, on the average, the ages ranging from 7 to 11 1/2; 15 were left for adoption; the rest of her data about the children cannot be compared with any of the figures from the present study. This seems to be all that is written in Sweden about the fate of these unwanted children.

The Danish author *F. B. Nielsen* (1960), reported that, of 92 children born after application for abortion had been refused, 2 were stillborn, 82 healthy and 8 abnormal in some respect. But his children, too, were too young to permit any conclusion on their mental health and social adjustment.

It is beyond the scope of this investigation to go into the lengthy debate that has been going on about the legislation governing premature termination of pregnancy. Extensive reviews of this are given in the publications of *Ekblad* (1955) and *Höök* (1963).

The problem of abortion was given particular attention in the December 12, 1964, issue of the Lancet, which contained articles by *Tredgold* and by *Uhrus* and a leading article on the subject. The leading article concurred with the demand made at a meeting of U.S.A. specialists in 1955 for "more research into the background, motivation, mechanisms and results" of therapeutic termination of pregnancy.

As therapeutic abortion was not regularized by law in Sweden until January of 1939, it has hardly been possible until now to determine the long-term social and psychiatric consequences for the children born after application for abortion has been refused. In 1960 we published the preliminary results of this study in Swedish.

Material

Unwanted Children

The subjects studied came from Göteborg, Sweden's second largest city, with a population of about 280,000 at the time in question–1939-1942. During these years, the city had only one large general hospital, the Sahlgren Hospital. In October of 1938, a psychiatric department was opened at the hospital, and among its other activities, this department served as a counselling center for mothers seeking legal abortion. During the years of relevance to the present study, it was the only center of this kind in Göteborg. The few cases

taken in hand by private practitioners during this period are not included in our series.

Thus, the material for this investigation originates from all the cases of women living in Göteborg who applied for a therapeutic abortion to the Psychiatric Department of the Sahlgren Hospital during the years 1939 to 1941, inclusive, and were refused. These included both the women coming only to the outpatient service and the ones hospitalized for observation. We took 1941 as the last year so that we could follow the children born of these pregnancies until the age of 21.

During the years 1939 to 1941, altogether 197 women living in Göteborg had 199 applications for legal abortion refused, 2 women having been refused for two pregnancies. These do not include any woman who changed her mind and took back her application. In 188 of the 199, the psychiatrist at the department decided against abortion, in 10 cases, which had been referred to the Medical Board, the Board refused to authorize the abortion, and in one case, also referred to the Medical Board, the Board authorized the abortion but the obstetrician refused to do the operation because the pregnancy had proceeded too far.

Three of the 197 women could not be traced. One was a refugee who lived only a short time in Sweden. It is impossible to explain why the other 2 could not be traced; they may have given a false name or only a temporary address. This left 194 women and 196 refused applications.

Sixty-eight of these 196 pregnancies ended in abortion, spontaneous or provoked. Sixty-eight out of 196 is a large percentage—34.7 percent—and undoubtedly many of them were illegal. Since the drop-out rate is indicative to some extent of the kind of subjects chosen for study—the narrower the indications for legal abortion, the greater the number of illegal abortions—it is interesting to compare this figure with those from other Nordic countries on the frequency of interrupted pregnancy after legal permission for abortion had been refused. There is not much point in comparing our figures with those of other than these countries because the conditions differ too much.

Lindberg (1948) found that only 50 (14.5 percent) did not give birth at the expected time out of all 344 women refused an authorized abortion after being admitted as inpatients to the Psychiatric Department of the Sahlgren Hospital between 1940 and 1946. *Hultgren*

(1959) found that 14.4 percent of 4,274 women whose petitions for abortion had been turned down by the Medical Board during 1954 to 1956 did not go through with their pregnancy; 224 of the 4,274 were from Göteborg, and 35 of these 224 (15.6 percent) did not go through with their pregnancy.

Thus the percentage of prematurely terminated pregnancies, spontaneous or provoked, was smaller in these two Swedish series than in ours. It is true that all *Lindberg's* women had been under observation as inpatients, as against only 49 of our 199. One probably does not get such a good psychotherapeutic grip on patients only coming to an outpatient service as one does when they are hospitalized. On the other hand, only 83 of 136 Danish women refused legal abortion after observation at the Psychiatric Department at Frederiksberg's Hospital went through with their pregnancies, the drop-out rate in this series thus amounting to 39 percent (*Delcomyn*, 1952).

A more probable explanation for the difference is this. *Lindberg's* series comes from 1940-1946, *Hultgren's* from 1954-1956, and ours from 1939-1941. In 1939 the number of legally authorized abortions in Sweden amounted to 439, in 1946 it rose to 2,378 and in 1951 it reached a peak of 6,328; it then fell slightly, amounting to about 5,000 in 1952-1954, 4,562 in 1955, and 3,851 in 1956. Another way of following the trend is to compare the number of legal abortions with the number of livebirths during the same period. During 1939 to 1942, 0.5 pregnancies were terminated by legal abortion for every hundred livebirths. In 1946 the proportion rose to 1.8, and in 1951 to 5.7. In 1952 and 1954 it was 4.8, in 1955 it was 4.3, and in 1956 it was 3.6.

In short, many more authorized abortions were done after than during the years of relevance to our investigation. Because it was harder to get permission for therapeutic abortion in 1939-1941 than later it is reasonable to assume that more illegal abortions were performed in our series than in later series. *Delcomyn* (1952), comparing the Danish figures for 1945-1949 with those for 1950 and the first half of 1951, found that there were relatively more authorized abortions in the second period, and also that a larger percentage of the women refused a legal abortion went through with their pregnancy the second period. She gave no figures for her observation.

Thus 128 of the pregnancies in our series (representing 126 women) proceeded to term. The result was 134 children, including 6 pairs of twins. Four of the 134 were stillborn, and 8 died within a

year, one before it was 2 and one before it was 3. Excluding these 14 cases of early death left 120 children. The present study is based on these 120 all of whom reached the age of 21. They include 4 pairs of twins and 2 twins whose partners had died. Table 1 shows the 120 divided by year of birth and sex.

TABLE 1. *The 120 children born after their mother's application for legal abortion was refused, by year of birth and sex*

Year of birth	Boys	Girls	Total
1939	9	6	15
1940	32	13	45
1941	17	22	39
1942	8	13	21
Total	66	54	120

Control Children

All but 1 of the 120 unwanted children were registered in Goteborg when they were born. We chose control subjects for these 119 as follows: When the infant was born in one of the city's maternity hospitals, we took the next same-sexed child born in the same hospital for its control subject. For the 17 born elsewhere, we took the first same-sexed child registered in the city hospitals on the same day. When the control subject died before the age of 21, we replaced it with the first same-sexed child born after it in the same hospital. For control subjects for twins, we took the next pair of twins, same-sexed or bi-sexed as the case was, born in the same hospital. For the 2 children of twin birth, one of whose partners was stillborn and one died within 3 months, we chose control subjects as if the original children were singletons.

For the control subject of the child born outside Göteborg we took the next child of the same sex registered in the book of the same parish.

Sources of Data Analyzed*

From the civil and parish registry offices we found out: whether the would-not-be mother had had her child after her application was turned down; the addresses of the unwanted children and their control subjects from birth until they reached the age of 21; the marital status of the children and whether they in turn had had any children. One control subject lived in another country for six months when she was 18; apart from this we were able to follow every subject from the time they were born until they were 21.

From the child welfare boards (see p. 132) in the various districts in which the subjects had lived, we learned whether they had any of the subject's names in their files and, if so, why.

At the child-guidance clinics and youth psychiatry centers in the districts where the subjects lived or had lived we asked whether they had been consulted for mental deviation or illness in any of the subjects. We did the same at all the mental hospitals and psychiatric departments in general hospitals, and at all the psychiatric outpatient services in the districts where the subjects had lived after the age of 15. We also wrote to all the rural and urban psychiatric consulting bureaus run independently of the psychiatric departments in the general hospitals. We were not able to cover all the private practitioners who might have been consulted and we therefore disregarded anything we happened to hear from one of them having been consulted.

Sweden has a central penal register for the whole country, where every act of the authorities restricting the liberty of an individual is recorded, whether it be sentence to an adult or juvenile prison or internment in some other kind of an institution; also every instance of exemption from legal punishment because of legal irresponsibility, fines above a certain level and fines for crimes for which the alternative is penal servitude. All cases of conditional sentence are also recorded there. After receiving special permission from the government, we went through these files to see whether we could obtain any further evidence of antisocial conduct on the part of the subjects until they reached the age of 21.

*In these analyses we have called a P value of <0.05 probably significant, of <0.01 significant and of <0.001 highly significant.

We also inquired at all the official temperance boards and social agencies in the districts where the subjects lived after the age of 16. (Not until 16 are persons registered in their own names in the records of the social agencies.)

We inquired about the subjects' schooling in the various school districts to which they belonged. Whenever they proceeded to secondary schools, we inquired at these schools whether they had gone on from them to other forms of study, and about any examinations they had passed. Thus we have full information on all the examinations the subjects passed prior to university. We then learned whether they had studied at any university before the age of 21 by going through the annual lists of the students enrolled at the various Swedish universities.

The information we got from the schools and the files of the social agencies showed that there was no point in inquiring at the agencies for the education and care of the mentally retarded.

In Sweden military service is obligatory for men, but not for women. We enquired at the Swedish Institute of Military Psychology about the fitness group into which the male subjects had been classed, and, if they had completed their military service, about how they had succeeded with their duties there. As a rule the young men must enroll for military service the year they become 18, but they can put it off up to the age of 21 or more for reasons of health or education. When they did this, we sometimes extended our limit beyond the 21st birthday in this one respect.

Three subjects (1 original and 2 control subjects) were the children of leading citizens in small communities, and we felt that it would be unfair to make inquiries about them in the local agencies in their neighborhood. But we got all the information we needed about them from other sources and there being no difference between them and the other subjects in depth of penetration we have included them with the others in the various analyses.

Differences Between Original and Control Series

Age, Maternal Age and Social Group

The ages of the two series of subjects correspond almost to the day. The greatest difference amounted to 25 days (twin cases).

The unwanted children were born to mothers 30 years old on the average, the control children to mothers of 28, on the average. There is a significant difference here ($0.01 > p > 0.005$).

We also compared the two series for the social group into which they were born, using the norms from the Swedish electoral statistics for the years 1937 to 1940. We did the grouping according to the father's occupation at the time, or if the mother was unmarried according to hers. Children adopted by couples neither of whom was their real parent, were grouped according to the occupation of the adoptive father at the time. But children adopted by men their mothers married after they were born were grouped according to their mothers' occupation when they were born. The result of this comparison is seen from table 2, which also shows how the inhabitants of Göteborg were distributed by social group in 1940.

More of the control than unwanted children were born into group II, and the reverse held for group III. Combining groups I and II gave 25 for the unwanted children and 36 for the control children, against 95 and 84 for group III. Thus the two series did not differ significantly in this respect ($p \simeq 0.10$), though no consideration was given to social group when choosing the control subjects.

Seventy-seven pairs, each consisting of one subject from either series, belonged to the same social group, 43 did not.

TABLE 2. *The unwanted and control children, by original social group*

	Number		Percentage		
Social group	Unwanted children	Control children	Unwanted children	Control children	Whole of Göteborg in 1940
I	3	4	2.5	3.3	6.5
II	22	32	18.3	26.7	31.4
III	95	84	79.2	70.0	62.1
Total	120	120	100.0	100.0	100.0

Results of Comparing Family and Social Environment of Unwanted and Control Children

Insecure Childhood

We considered that the following circumstances in the history of the subjects pointed to an insecure childhood background:

1. Complaints to a child welfare board about the way the subjects were being treated at home.

Every local authority district in Sweden is required to set up a child welfare board whose duty is to see that all children in its district are properly cared for. Up until 1960 the boards were required to interfere whenever children under 16 were being exposed to physical or mental harm through cruelty or neglect at home, or in danger of becoming delinquent because of their parents' depravity, negligence, or inability to bring up their children.

2. The child taken into custody by a child welfare board for protective care.

If consulting with, advising or warning the parents had no effect, or if the board decided that it would be a waste of time to try to persuade the parents to mend their ways, the board had the right to take the child away from its parents for protective custody.

3. Placement in a foster home.
4. Placement in a children's home.
5. Childhood in broken home, i.e. loss of a parent through divorce or death before the child was 15, or birth out of wedlock not followed by legitimization.

Table 3 shows how many subjects in either series were brought up under each of these circumstances. As seen there, 32 (26.7 percent) of the unwanted children were born out of wedlock, against only 9 (7.5 percent) of the control children. The difference is highly significant ($p < 0.001$). Eighty-six pairs (one member from each series) agreed in regard to legitimacy; 34 did not. The parents legitimized 5 of the 32 unwanted children born out of wedlock by getting married 2 to 24 months after they were born, and the parents of 5 of the 9 illegitimately born control children did the same 2 to 33 months later. Eight of the unwanted children were adopted by others than their

real parents (7 of these were illegitimate). None of the control subjects were adopted.

According to the criteria laid down, 72 (60 percent) of the unwanted children had an insecure childhood, as against only 34 (28.3 percent) of the control children. If one disregards the stays in children's homes, many of which were for only a short while, the figures change to 65 (54.2 percent) against 26 (21.7 percent), and the difference remains highly significant ($p < 0.001$).

In short, it is obvious that the children born after an application for abortion had been refused ran a greater risk of insecurity in childhood than did their control subjects.

TABLE 3. *Comparison between unwanted and control children for circumstances in history pointing to insecurity in childhood (The same child may occur in several categories)*

Circumstances pointing to insecure childhood	Unwanted children		Control children	
Report to children's aid bureaus about unsatisfactory conditions at home	17		6	
Child removed from home by authorities	2		0	
Placement in foster home	19		4	
Placement in children's home	30		10	
Parents divorced before child was 15	23		13	
Parent(s) died before child was 15	10	60	5	22
Born out of wedlock and never legitimized	27		4	
Born out of wedlock and legitimized	5		5	

Disposition to Move to Other Local Authority Districts

There being more delinquency in cities than in other regions we determined how many of either series had stayed the whole time in Göteborg. Another reason for doing so was that we had unusually good possibilities of getting complete information about these subjects since our place of work is in Göteborg. We also checked whether they differed in tendency to move from place to place.

Seventy-seven (62.2 percent) of the unwanted children stayed in Göteborg until they were 21, and 85 (70.8 percent) of the control subjects. Twenty-one (17.5 percent) of the unwanted children had lived in three or more local authority districts, and 19 (15.8 percent) of the control subjects. Thus the two series agreed well, both for permanency of residence in Göteborg, and for tendency to move from one district to another. There were 55 pairs in which both the original and control subject had lived the whole time in Göteborg.

Results of Comparing Personal Data in Original and Control Series

Psychiatric Consultation and Hospitalization

Thirty-four of the unwanted children (28.3 percent) had gone to a psychiatric clinic of some kind or received psychiatric care in a hospital. The corresponding figure for the control subjects was 18, or 15 percent. The difference is probably significant ($0.025 > p > 0.01$).

Twenty-nine of the unwanted children had been under the care of a child psychiatrist, 28 only as an outpatient, and one as an inpatient as well. Six had visited a center for adult psychiatry; 3 of these had been hospitalized, one in a psychiatric department at a general hospital, one at a mental hospital, and one at both. One of the latter belonged to the 29 who had gone to an outpatient department for child and youth psychiatry.

Fifteen of the control subjects had visited a center for child psychiatry, all of them only for outpatient treatment. Four had been patients at a center for adult psychiatry, 2 as an outpatient, one at a mental hospital, and one at both a mental department in a general hospital and a mental hospital. One of these 4 belonged to the 15 who had gone to a center for child psychiatry.

The question arises: Was it because the mothers of the unwanted subjects had been in contact with psychiatrists before the children were

born that so many of these children were registered at centers for child psychiatry? It may be that, having once consulted a psychiatrist, these mothers found it easier to do so again, whereas the mothers of the control subjects, who had seldom if ever consulted a psychiatrist about themselves, did not go to a psychiatrist for their children unless something was seriously wrong. Likewise, the mothers who had consulted a psychiatrist about abortion might be more apt than others to seek psychiatric advice for other personal troubles afterwards, and if they then complained about their children being nervous, the child might very likely be sent to a psychiatrist while the perhaps equally nervous children of other mothers might not.

In 1959 we determined how many of the mothers up to that year had consulted a psychiatrist for matters not directly concerned with the abortion, but only among the mothers of the 57 pairs in which both partners had lived in Göteborg all the time up to then. Twenty-seven of the 57 would-not-be mothers had gone to one of the municipal psychiatric outpatient departments for complaints not directly concerned with the abortion, and 10 of their children had done so. The corresponding figures for the control series were 9 and 0. It is apparent from this that it was not because the would-not-be mothers had consulted a psychiatrist about abortion that these children went more often than the others to a child psychiatrist. When all the subjects reached the age of 21, the number of pairs living the whole time in Göteborg dropped to 55, but we did not consider it worth while to do the analysis again for this sake.

Delinquency and Crime

Our figures for acts of delinquent nature reported to the child welfare boards do not cover drunken misconduct; this will be taken up in the next section.

Twenty-two (18.3 percent) of the unwanted subjects, 19 boys and 3 girls, were registered with the child welfare boards for delinquency, against 10 (8.3 percent) of the control subjects, 9 boys and one girl. The difference is probably significant ($p < 0.05$).

The boards had made investigations in 12 of the first 22 subjects and in 4 of the second to determine whether formal charges brought against them should be dropped. This happened 19 times in the

original series, 8 times in the control series. Three of the first series and one of the second were removed from their homes and placed in protective custody elsewhere, in accordance with the law then in force, according to which correctional measures must be undertaken when children under 18 show severe forms of maladjustment. One of these 3 unwanted children, as well as the control subject, was sent to a reformatory.

The penal register contained the names of 10 of the unwanted children (8.3 percent) and of 3 control subjects (2.5 percent). The difference is not significant ($0.10 > p > 0.05$). Nine of the first 10 were male, one was female. The control subjects were all male.

Drunken Misconduct

The records of the official temperance boards contained the names of 19 of the unwanted children (15.8 percent) and 13 control subjects (10.8 percent) for drunken misconduct. The difference is not significant ($0.50 > p > 0.30$). Two of the first 19 subjects were women. The 13 control subjects were all men.

Public Assistance

Seventeen of the unwanted children (14.2 percent) had received some form of public assistance between the ages of 16 and 21, and 3 of the control subjects (2.5 percent). The difference is significant ($0.005 > p > 0.001$).

Only one subject, a boy in the control series, received a disablement pension from the government; he was an idiot and permanently institutionalized.

Educational Subnormality

Under this heading we included all the uneducable subjects, the ones taught in special schools for the mentally retarded, those whose last year at school was spent in a special class. In the last group we also included a few subjects whose educational subnormality was well documented, but who were taught in ordinary classes because there was no form of special training available for them.

The large cities have a graduated series of special classes in the ordinary schools called remedial reading classes, observation classes,

extra classes and health classes, but we paid no attention to the kind of special class the subjects pupil attended, mostly because it depended on where they lived what kind of class they could choose from.

According to these criteria, 13 of the unwanted children (10.8 percent) were educationally subnormal, as against 6 of the control subjects (5.0 percent). This difference is not significant ($p = 0.10$).

There was one case of well documented mental retardation both in the original and in the control series.

Theoretical Studies Beyond the Obligatory

On drawing a line between the subjects who had done more advanced theoretical study than that required by the school law, and those who had not, we found that only 17 (14.2 percent) of the unwanted had had some form of higher education, as against 40 (33.3 percent) of the control subjects. The difference is highly significant ($p < 0.001$).

Eight unwanted and 12 control children had taken university entrance examinations. Five unwanted children and 11 control children had studied at a university. Neither of these differences is significant.

As mentioned (table 2), more of the control than original subjects came from social group II and the reverse was true for social group III. As a child's education depends a great deal on the social standing of its parents, we also compared the schooling in the two series after excluding the subjects left over when the two kinds of subjects were paired according to social group. This left 77 subjects in each series. Ten of these 77 (13.0 percent) unwanted children had had some form of higher education, against 21 of the 77 control children (27.3 percent). The difference is probably significant ($p < 0.05$).

One can also study the effect of social standing on the education by taking one social group at a time; for this we had to combine groups I and II, as there were too few cases in group I. Five of the 95 unwanted children (5.3 percent) coming from group III had had higher education, against 17 of the 84 control subjects (20.2 percent) coming from the same social group. The difference is significant ($p < 0.01$). The figures for group I + II were 11 out of 25 (44.0 percent)

against 28 out of 36 (77.8 percent). Here the difference is probably significant ($p < 0.05$).

Continuing with these calculations, chi square amounts to 7.93 for social group III and to 5.89 for I and II combined. The sum, 13.82, with 2 degrees of freedom gives a p of <0.001, showing a highly significant difference for the three social groups combined.

Thus it was not differences in proportion of different social groups that caused the difference in schooling between the unwanted and control children.

Military Service

Ten of the 66 males in the original series (15.2 percent) were judged unfit for military service, either at the time of enrollment or after they had started, as opposed to 4 (6.7 percent) of the control subjects. This is not a significant difference ($0.20 > p > 0.10$). According to our information, 4 of the 10 first males were exempted for mental reasons; our information in this respect may not be complete, however. Two of the control subjects were exempted on these grounds.

When a Swedish recruit enrolls, he is classified into one of four groups according to his fitness for military service, from group 1 for a completely satisfactory condition down to group 4 who are assigned to fatigue duty. Apart from exemption from service, our two series were distributed very much alike by fitness for military service.

Marital Status and Parenthood

As we only followed our subjects up to the age of 21, we cannot say much about how they compare with regard to marriage and parenthood. Some differences did emerge, however.

Twenty of the unwanted children (17 women, 3 men) married before the age of 21, and 14 of the control subjects (9 women, 5 men). The difference is not significant here, either for the sexes combined or for one of them.

Two of the female subjects from the original series had also divorced before the age of 21; none of the control women had done so, and no man from either series.

We restricted our analysis of parenthood to the women, as there was no hope of getting reliable figures for the men in this respect.

Fourteen out of 54 women from the original series had had 19 children before they were 21, 4 out of wedlock, and 7 of the 54 female control subjects had had 9 children, 3 out of wedlock.

It is impossible to draw any conclusions from these figures. It will be noted, however, that the control series (which had more education on the whole) contained fewer cases of early marriage and of young mothers. This tallies with the observation that the age of marriage and parenthood rise with the degree of education.

Freedom From Defect in All Respects Studied

Sometimes the same subject will occur in more than one of the groups studied here. Thus a subject registered with the authorities for abuse of alcohol will often be found in the files of the centers for child psychiatry as well; a man who has been in a mental hospital will sometimes be exempted from military service; an uneducable subject will be registered as receiving public assistance, as being educated in a special class, and so on. It is interesting, therefore, to compare the two series for the number of subjects showing no defect in any of the respects studies, i.e., registration for antisocial behavior in the books of the child welfare boards or penal register; official registration for drunken misconduct; education in a special class or school, or uneducability; public assistance or government pension; visits to psychiatric inpatient or outpatient departments during childhood or adulthood. Fifty-eight (48.3 percent) of the unwanted children showed none of these defects against 82 (68.3 percent) of the control subjects. The difference is significant ($0.005 > p > 0.001$).

Taking social group III separately from I and II combined showed the following: Forty of the 95 unwanted children (42.1 percent) coming from group III showed no defect, against 54 of the 84 control subjects (64.3 percent) from the same group. The difference is significant ($0.005 > p > 0.001$). The corresponding figures for group I and II combined were 19 out of 25 (76.0 percent) against 28 out of 36 (77.8 percent). Here the difference is not significant.

The same analysis of the 77 pairs concordant for social group gave 34 unwanted cases (44.2 percent) showing no defect, against 54 control (70.1 percent). The difference is significant ($0.005 > p > 0.001$).

Similar analysis of the 55 pairs living in Göteborg the whole time gave 20 (36.4 percent) showing no defect against 38 (69.1 percent). The difference is highly significant ($p < 0.001$).

As children from broken homes are more apt than others to be antisocial and mentally disturbed, we compared the two series for the number of cases showing none of the aforementioned defects among the subjects who had lived with both their real parents until they were 15. Thirty-three out of the 60 such subjects from the original series (55.0 percent) showed none of these defects, and 68 out of the 98 control subjects of this category (69.4 percent). The difference is not significant ($0.10 > p > 0.05$).

Discussion

Table 4 gives a survey of the ways in which the children born after their mother had been refused a legal abortion differed from the control series of same-aged subjects chosen at random. As seen there, the unwanted children were worse off in every respect, the only exception being due to the one case of a government pension which came from the control series. The differences were often significant, and when they were not, they pointed in the same direction (except for the case just mentioned)—to a worse lot for the unwanted children.

When one looks for a reason for the differences, one is struck mostly by the greater frequency of factors tending to disrupt the stability of the home in the case of the unwanted children, such as birth out of wedlock, and death or divorce of their parents while they were still young. In other words, not as many unwanted children were brought up by both their real parents as were control subjects. Probably as a corollary of this, more of them were brought up by foster parents of in children's homes. But the latter may also have been a consequence of the greater number of complaints to the children's welfare boards about the way in which they were being treated at home.

The difference that turned up most consistently in various forms of analysis was the difference in amount of education. Whatever categories of subjects were studied—different social ranks or different subgroups of the same social rank—the unwanted children got a significantly smaller amount of education than the control subjects.

The reason the unwanted children had had so much contact with psychiatrists was probably not—as we showed—that their mothers

TABLE 4. *Survey of important differences between the unwanted and control children*

	Unwanted children			Control children			
	No. in resp. series	Feature present		No. in resp. series	Feature present		Level of sign. of differ.
		No.	%		No.	%	
Psychiatric consultation and hospitalization	120	34	28.3	120	18	15.0	*
Registration for delinquency at children's aid bureaus	120	22	18.3	120	10	8.3	*
Registration for crime in Penal Register	120	10	8.3	120	3	2.5	–
Registration for drunken misconduct	120	19	15.8	120	13	10.8	
Public assistance between age of 16 and 21	120	17	14.2	120	3	2.5	**
Subnormal educability or uneducability	120	13	10.8	120	6	5.0	–
Theoretical studies beyond the obligatory:							
Whole series	120	17	14.2	120	40	33.3	***
Subjects in pairs congruent for social group	77	10	13.0	77	21	27.3	*
Subjects from social group III	95	5	5.3	84	17	20.2	**
Subjects from social groups I + II	25	11	44.0	36	28	77.8	*
Exemption from military service	66	10	15.2	66	4	6.7	–
Freedom from inferiority in above respects:							
Whole series	120	58	48.3	120	82	68.3	**
Social group III	95	40	42.1	84	54	64.3	**
Social groups I + II	25	19	76.0	36	28	77.8	–

Subjects in pairs congruent for social group	77	34	44.2	77	54	70.1	**
Subjects living all their life in Göteborg	55	20	36.4	55	38	69.1	***
Subjects brought up by both their real parents	60	33	55.0	98	68	69.4	

found it easier to consult a psychiatrist about their child because they had once before consulted a psychiatrist about themselves. It was probably because these mothers were more vulnerable mentally than the others, and passed on this failing to their children, either through genes or through the effect it had on the home environment, or both.

The investigation has shown that children born after their mothers have been refused permission for legal abortion are born into a worse situation than other children. From this one may assume that the children who are not born because their mothers get authorization for abortion would have had to face still greater disadvantages, socially and mentally. Thus, the very fact that a woman seeks an authorized abortion, no matter how trivial her grounds may appear to some, means that the expected child will run a larger risk than its peers of an inferior standing in life. In our opinion, the present investigation shows that the provisions for therapeutic abortion in the law should not only aim to prevent the private tragedy; they should also aim to improve mental hygiene in a wider sense. Thus the legislation should also consider the social handicaps awaiting the unwanted child, not only, as it does now, the genetic risk in the narrow sense of the terms.

SUMMARY

The authors examined 120 children born after their mothers had applied for therapeutic abortion on psychiatric grounds and been refused, comparing them with an appropriate control series of the same size. All the subjects studied lived and were followed up until the age of 21. Data were assembled from civil and ecclesiastical registry offices, social agencies, school authorities, military authorities and all the psychiatric inpatient and outpatient departments everywhere the

subjects had lived. It was ascertained how many of each series had been registered for mental ill-health, antisocial and criminal actions, drunken misconduct, and different forms of public assistance; for the men it was ascertained how they had got on during their military service; likewise the marital status, number of children, and school ability and educational level was determined.

A study of the social features revealed that many more of the unwanted than control children had not had the advantage of a secure family life during childhood. They were also registered more often in psychiatric services, and a few more of them than control subjects received psychiatric care. They were more often registered for antisocial and criminal behavior, and slightly more often for drunken misconduct, and they got public assistance more often than the control subjects. A few more of them were educationally subnormal and far fewer had pursued theoretical studies over and above what is obligatory. They were more often exempted from military service. More of the females married early and had children early than in the control series. The differences between the two series in these respects were often statistically significant, and when they were not significant they always pointed in the same direction—to the unwanted children being born into a worse situation than the control children. Table 4 gives figures for most of the features just mentioned.

The authors conclude that the very fact a woman applies for legal abortion means that the prospective child runs a risk of having to surmount greater social and mental handicaps than its peers, even when the grounds for the application are so slight that it is refused. In their opinion, the legislation of therapeutic termination of pregnancy should also consider the social risks to which the expected child will be exposed.

REFERENCES

Arén, P. (1958): Undersökning av 100 nyblivna mödrar med legal abort i anamnesen (One hundred newly delivered mothers with a history of legal abortion). *Svenska Läk.-Tidn. 55*, 505-522.

Arén, P., & C. Ämark (1957): Prognosen vid beviljad men icke utförd legal abort (Outcome in cases of authorized but not performed therapeutic abortion). *Svenska Läk.-Tidn. 54*, 3709-3784.

Delcomyn, K. (1952): Efterundersogelse af Kvinder, der har faet Afslag pa Anmodning om Abortus provocatus (Follow-up study of women whose application for therapeutic abortion was refused). *Nord. Med. 48*, 980.

Ekblad, M. (1955): Induced abortion on psychiatric grounds. *Acta psychiat. scand.*, supp. 99.

Forssman, H., & I. Thuwe (1960): En socialpsykiatrisk efterundersökning av 120 barn födda efter avslag pa abortframställning (Mental health and social adjustment of 120 children born after application for therapeutic abortion refused). *Nord. psykiat. T. 14*, 265-279.

Hultgren, G. (1959): Avslag på ansökan om legal abort (Application for legal abortion refused). *Nord. Med. 62*, 1182-1185.

Höök, K. (1963): Refused abortion. A follow-up study of 249 women whose applications were refused by the National Board of Health in Sweden. *Acta psychiat. scand.*, supp. 168.

Lancet (1964): Termination of pregnancy on psychiatric grounds, Leading article in II, Dec. 12.

Lindberg, B. F. (1948): Vad gör den abortsökande kvinnan när psykiatern sagt nej? (What does the woman do when the psychiatrist says no to her application for abortion?). *Svenska Läk.-Tidn. 45*, 1381-1391.

Malmfors, K. (1951): Den abortsökande kvinnans problem (Problems of the woman seeking abortion). *Svenska Läk.-Tidn 48*, 2445-2468.

Nielsen, F. B. (1960): Afgorelser i et Modrehjelpssamråd og en Efterundersogelse (Decisions by a maternity assistance board and a follow-up study). *Ugeskr. Laeg. 120*, 330-335.

Schlaug, R. (1952): Om de abortsökande kvinnoras män (The male partners of women applying for therapeutic abortion). *Svenska Lak.-Tidn. 49*, 849-862.

Svensk författningssamling (Swedish Statue Code) (1938): Lag om avbrytande av havandeskap (Legislation on abortion). No. 318. Stockholm.

Sveriges officiella statistik (Official Swedish statistics) (1941): Riksdagsmannavalen aren 1937-1940 (Government election statistics for 1937-1941). Stockholm.

Sveriges officiella statistik (Official Swedish statistics) (1959): Allmän hälso- och sjukwärd 1957 (Public health and care of the sick in 1957). Stockholm.

Text till lag om samhällets barnavärd och ungdomsskydd (Proposed wording for the legislation governing official supervision of child welfare and protection of youth) (1950): Svenska socialvärdsförbundet (Swedish Social Welfare Association), Stockholm.

Tredgold, R. F. (1964): Psychiatric indications for termination of pregnancy. *Lancet*, 12 Dec., *7372*, 1251-1254.

Uhrus, K. (1964): Some aspects of the Swedish law governing termination of pregnancy. *Lancet*, 12 Dec. *7372*, 1292-1293.

Item No. 46

The public health aspects of abortion have still not received the attention they deserve. After reviewing various facets of the problem with specific reference to hospitals in the United States, the author proposes emphasis on abortion law reform, promotion of sex education, and pursuit of an active contraceptive program.

ABORTION IN AMERICAN HOSPITALS

Robert E. Hall, M.D.

THE practice of abortion in American hospitals is inequitable, inconsistent, and largely illegal. The basic reason for this is that this aspect of twentieth-century medicine is governed by nineteenth-century laws.

With minor exceptions the laws in all 50 states permit abortion only "if necessary to preserve the life of the mother." Yet, as medicine has progressed, it has become apparent that considerations other than the preservation of maternal life are involved in the practice of abortion.

Only 25 years ago the risk to the maternal life of women with heart disease, diabetes, and tuberculosis was sufficient to warrant interruption of their pregnancies in compliance with the law. Most abortions then were done for such reasons. Now increased medical knowledge has enabled us to carry many of these women safely through pregnancy; but, at the same time, other medical discoveries have revealed to us equally valid reasons for therapeutic abortion, which do not necessarily entail danger to maternal life.

Need for Abortion Law Reforms

Chief among these new-found indications are psychiatric disease and maternal rubella. The ominous implications of both of these conditions were not known when the abortion laws were written. Since the laws have not yet been changed in conformity with these advances in medical science, doctors today are forced to break the law in order to practice modern medicine. And since fully half of the hospital abortions today are performed for psychiatric disease and maternal rubella, it is readily apparent that the law is being broken fairly often.

In the United States, where abortion laws are strict, the ratio of therapeutic abortions to live births is 1:500 and the ratio of illegal abortions to hospital abortions is 100:1. In Denmark, where the abortion law is liberal, the ratio of therapeutic abortions to live births is 1:20 and the ratio of illegal abortions to hospital abortions is 4:1. In Japan, where abortion has been legalized, there are as many abortions as live births. These figures are based, of course, on educated estimates only, but they do serve to illustrate (a) that hospital abortions are exceptionally rare in this country and (b) that the demand for abortion is met illegally when it cannot be satisfied through legal channels. The one million criminal abortions thought to be performed in this country every year

comprise a public health problem of pandemic proportions.

Needless to say, there are no statistics available to document the psycho-socio-medical sequelae of these million criminal abortions, but they are obviously extensive and they are suffered almost exclusively by those who cannot afford the skilled abortionist's fee. Infected-abortion cases abound on our charity wards, not in our private pavilions. To a degree the medical profession is responsible for this dichotomy through its inequitable distribution of therapeutic abortions among ward and private patients.

Rate of Therapeutic Abortions

National surveys bear testimony to the fact that hospital abortions are performed four times as often on the private services as on the ward services.[9,14] In New York City, between 1960 and 1962 the ratio of therapeutic abortions to live births in the proprietary hospitals was 1:250; on the private services of the voluntary hospitals, 1:400; on the ward services of the same voluntary hospitals, 1:1,400; and in the municipal hospitals, 1:10,000. The same inequity pertains to ethnic origin. The rate of therapeutic abortions per live births among white women in New York is 1 per 380, among nonwhites 1 per 2,000, and among Puerto Ricans 1 per 10,000. Approximately half of the puerperal deaths among New York's Negroes and Puerto Ricans are due to criminal abortions, as opposed to only a quarter of the puerperal deaths among white women.[2] This surely is a problem in preventive medicine which public health measures could help to solve.

Over all, criminal abortion as a cause of maternal mortality is on the upswing. Concurrently, the relative and absolute incidence of hospital abortion is decreasing. Whereas about 20 years ago there was one therapeutic abortion per 150 live births, now there is one per 500.[5] Aside from the lessened need for abortions on purely medical grounds, the principal reason for this decline has been the establishment of therapeutic abortion boards. These boards have become increasingly prevalent in the past 15 years, partly due to the mistaken belief that they are required by the Joint Commission on Accreditation of Hospitals. At present about half of our teaching hospitals have such boards.

In theory these boards serve to police the abortion practices of staff physicians, to prevent them from yielding to the pressure of undeserving patients, and to protect them from possible litigation. In fact these boards serve as medical tribunals which are frequently called upon to render moral judgments. Through the detachment typical of committees in general, this judgment is likely to be more academic than humane. After the establishment of such a board at Sloane Hospital, for example, the therapeutic abortion rate declined by one-third.[5]

Abortions for Rubella

It took many years to convince these boards that they should approve abortions for rubella. The ravages of rubella in pregnancy include a fetal death rate of 16 per cent, a prematurity rate of 16 per cent, a deformity rate of 17 per cent, and a 30 per cent incidence of congenital deafness.[13,6] Most of these dangers have been known to the medical profession for 25 years, but at first no abortions were done for this reason because it was argued that such abortions are, after all, illegal. The first rubella abortions were done under psychiatric guise upon the wives of insistent physicians. And now, as the knowledge of rubella deformities has become widespread, the general public has become equally insistent and obstetricians have been forced to comply with their demands in open defiance of the law. Dur-

ing the 1964 epidemic 329 such abortions were done in New York City alone.[3] Although most American hospitals now permit abortions for rubella, some do not. This inconsistency sometimes proves tragic to the individual rubella victim, for even the more liberal abortion committees usually refuse to approve the abortion of a woman who has had her previous obstetrical care at another hospital. As an illustration of the farcical extent of this situation, nine San Francisco obstetricians have been ordered to appear before the State Medical Board on the charge of unprofessional conduct for having performed therapeutic abortions for rubella, whereas at the same time in New York City a hospital is being sued for refusing to perform an abortion on a woman with documented first-trimester rubella which resulted in the birth of a deformed infant.

Abortions for Psychiatric Disease

A different set of inequities is associated with the psychiatric aspects of abortion. In order to comply with the law, abortions for psychiatric disease can be done only if there is a risk of suicide, yet suicide is known to be rare among pregnant women. In New York City, for example, where the suicide rate among women in the reproductive age range is 5.5 per 100,000, the rate among pregnant women in 1953 was 0.5 per 100,000.[7] For this reason, some hospitals refuse to sanction any abortions on psychiatric grounds.[12] In most hospitals, however, the psychiatrists are willing to exaggerate the risk of suicide in order to protect the overall well-being of their patients. As a consequence, about 10 per cent of today's hospital abortions are done for psychiatric conditions.[1,4,8,10,11] Needless to say, it is the private patient who most often profits from this rationale. At Sloane Hospital in the 1950's there was one abortion for psychiatric reasons per 1,119 deliveries on the ward service and one per 101 deliveries on the private service.[5]

Abortion policies vary not only from hospital to hospital but also from service to service within the same hospital. They also vary widely from doctor to doctor on the same service of the same hospital. In one of the large teaching hospitals in the East, for example, the individual abortion-to-delivery ratio of its staff members ranges from 1:110 to 1:11.

The victim of all this confusion is, of course, the American female. Even if she has a legitimate reason for therapeutic abortion she must find Doctor X in hospital Y with policy Z in order to have it done. If she makes the slightest deviation from this route she must seek a criminal abortion or raise an unwanted child. And it is the unwanted child of today who becomes the battered child of tomorrow.

A growing number of prestigious individuals and organizations have recently come to recognize the enormity of this problem and to recommend the abortion law reform necessary as a first step in its solution. Among these groups are the American Law Institute, the New York Civil Liberties Union, the New York Academy of Medicine, the California Medical Association, the American Association of Planned Parenthood Physicians, and the Unitarian Universalist Church. All of these groups have given public support to proposals at least as liberal as that recommended by the American Law Institute in its Model Penal Code, which provides that abortion should be permitted when the mother's mental or physical health is endangered, when there is a significant risk of fetal deformity, and in cases of rape and incest. Bills embodying these proposals have been introduced before the Legislatures of California and New York. Although considerably less liberal than the laws in Scandinavia, Japan, the

Communist world, and the law soon to be enacted in England, these bills represent an enlightened effort to update archaic legislation.

Suggestions for APHA

The public health aspects of abortion have, in my opinion, been too long overlooked. One million cases of cholera every year would create a public health scandal, or even a million cases of rickets. But one million criminal abortions every year are embarrassingly ignored. There are three important approaches to this problem which the American Public Health Association would do well to consider: (1) The promotion of sex education in our schools. In granting that our children are participating in a sexual revolution, are we not remiss in failing to provide them with intelligent guidelines? (2) The pursuit of an active contraceptive program.[4] In recognizing that birth control is an important public health measure, are we not remiss in failing to provide it as a public health service? (3) The sponsorship of abortion law reform. In conceding that the practice of abortion in American hospitals is inequitable, inconsistent, and largely illegal and that this situation is largely due to the impossibility of practicing twentieth-century medicine under nineteenth-century law, are we not remiss in failing as individuals and as organizations to stand up and be counted?

REFERENCES

1. Boulas, S. H.; Preucel, R. W.; and Moore, J. H. Therapeutic Abortion. Obst. & Gynec. 19:222-227 (Feb.), 1960.
2. Gold, E. M.; Erhardt, C. L.; Jacobziner, H.; and Nelson, F. G. Therapeutic Abortions in New York City: A 20-Year Review. A.J.P.H. 55:964-972 (July), 1965.
3. Gold, E. M. Personal communication.
4. Guttmacher, A. F. Therapeutic Abortion in a Large General Hospital. Surg. Clin. North America (Apr.), 1957, pp. 459-469.
5. Hall, R. E. Therapeutic Abortion, Sterilization, and Contraception. Am. J. Obst. & Gynec. 91:518-532 (Feb.), 1965.
6. Jackson, A. D. M., and Fisch, L. Deafness Following Maternal Rubella. Lancet 2:1241-1244 (Dec.), 1958.
7. McLane, C. M. In: Abortion in the United States. Calderone, M. S. (ed.). New York: Paul B. Hoeber, 1958, p. 140.
8. Ninnander, K. R., and Klein, M. Changing Attitudes Toward Therapeutic Abortion. J.A.M.A. (in press).
9. Rossi, A. S. Abortion Laws and Their Victims. Trans-action 3:7-12 (Sept./Oct.), 1966.
10. Russell, K. P., and Moore, J. G. Maternal Medical Indications for Therapeutic Abortion. Clin. Obst. & Gynec. 7:43-53 (Mar.), 1964.
11. Scherman, Q. Therapeutic Abortion. Obst. & Gynec. 11:323-335 (Mar.), 1958.
12. Thornton, W. N., Jr. Therapeutic Abortion. Responsibility of the Obstetrician. Obst. & Gynec. 2: 470-475 (Nov.), 1953.
13. Warkany, J., and Kalter, H. Congenital Malformations. New England J. Med. 265:993-1001 (Nov.), 1961.
14. Westoff, C. F., and Ryder, N. B. Personal communication.

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Item No. 47

Therapeutic abortion, sterilization, and contraception

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IN AN EFFORT to assess the current birth control practices in the United States, the experience of the Sloane Hospital for Women has been analyzed for the years 1951 through 1960 and a survey of 65 major American hospitals has been made. The data thus obtained will be presented in three separate parts: Therapeutic Abortion, Sterilization, and Contraception.

I. Therapeutic abortion

On Sept. 1, 1955, a Therapeutic Abortion Board was formed at Sloane Hospital. Prior to this date the mechanism for obtaining permission to perform an abortion, although it entailed approval of the Chief of Service, was considerably less formal. Since this date abortion applications have been reviewed by a three-member board composed of a senior obstetrician, internist, and psychiatrist. Because of this abrupt change in policy, the abortion cases for this study were selected from the time period between Sept. 1, 1950, and August 31, 1960.

Incidence. During these study years, the ratio of therapeutic abortions to deliveries was as follows:

	Ward	*Private*	*Total*
1950 through 1955	1:141	1:37	1:69
1956 through 1960	1:429	1:111	1:225
1950 through 1960	1:224	1:55	1:110

As can be seen from these figures the incidence of abortions following establishment of the Board has been almost precisely one third of that during the previous 5 years, and abortions were performed four times more frequently on the private service than on the ward service.

Case material. Of the 118 ward patients in this series, 69 were Caucasian, 47 were Negro, and 2 were Oriental. The Caucasian: Negro ratio of 1.5:1 is almost identical to the 1.4:1 ratio on the entire ward obstetrical service. Of the 248 private patients, 247 were Caucasian, none was Negro, and one was Oriental.

In the entire series, 15 patients were under the age of 20, 61 were between 20 and 24, 92 between 25 and 29, 84 between 30 and 34, 73 between 35 and 39, and 41 were more than 39 years old.

One hundred and ninety-nine patients were Protestant, 80 were Jewish, and 69 were Catholic. Twenty-two per cent of the white patients were Catholic.

Two hundred and seventy-six of the patients were married; 90 or 25 per cent were not.

Three hundred and nine or 84 per cent of the patients were less than 13 weeks pregnant, 51 were between 13 and 16 weeks, and 6 were between 17 and 20 weeks.

Type of surgery. The various surgical methods by which these abortions were performed are listed in Table I.

Indications. The indications for the abortions are presented in Table II.

Sterilizations. Sterilization procedures which were carried out in conjunction with

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therapeutic abortions are enumerated in Table III. Sterilizations were two and one-half times more common on the ward service.

Repeat abortions. The patients in this series who underwent more than one therapeutic abortion are recorded in Table IV. Twelve of these 20 women were sterilized at the time of their last abortion. The indications for the abortions were of a psychiatric nature in only 4 instances. Twelve were private patients and 8 were ward patients.

Legality. In New York State abortion is illegal "unless the same is necessary to preserve the life of the woman or of the child with which she is pregnant." The customary latitude adopted in interpreting this law is exemplified by the contrast between the arbitrarily compiled Groups A and B in Table V.

Experience at other hospitals. Questionnaires were sent to the directors of the obstetrical services of 65 randomly selected major hospitals, requesting the number of ward and private deliveries and therapeutic abortions performed on their services during any recent year or years. Useful information was received from the 60 hospitals listed in Table VI. As indicated by this table, 45 of the hospitals have both ward and private services, ten have ward services only, and five have private services only.

Among the 45 hospitals with both ward and private services, the incidence of therapeutic abortions was higher on the private services in 36; there were no ward or private abortions performed at five other hospitals, which reported 7,869 ward and 1,759 private deliveries; and the incidence of abortions was higher on the ward services of four hospitals which collectively performed only 8 abortions during the years chosen for review. No therapeutic abortions were done on 23 of the 55 ward and 9 of the 50 private services.

There is, of course, some statistical inaccuracy involved in appraising the combined incidence of therapeutic abortions at these various hospitals, for neither the size, the composition, nor the duration of the individual series is constant. It is nevertheless not without significance that the over-all frequency of therapeutic abortions at 60 outstanding American hospitals is 3.6 times higher on their private services than on their ward services. This is consistent with the New York City data presented in Table VII.

Comment.

The ward-private ratio of therapeutic abortions. The incidence of therapeutic abortions is strikingly higher on the private services than on the ward services. This has been observed before.[2-6] How can it be explained?

Part of the explanation lies in the dual tendency of the ward patients to register for antepartum care later in their pregnancies and to be less aware of their need to be aborted. That even this obstacle to ward-private equality can be overcome has been shown at Mount Sinai Hospital in New York, where the abortion rates for the two services between 1952 and 1955 were virtually identical.[7]

Another part of this discrepancy may be attributed to the higher incidence of abortions for psychiatric indications among private patients. Whereas at Sloane Hospital one therapeutic abortion was performed for psychiatric reasons per 1,149 deliveries on the ward service, the comparable ratio for the private service was one per 104. Psychotherapy is known to have been given to 19 of 22 ward patients (86 per cent) and only 69 of 118 private patients (57 per cent) who had abortions for psychiatric reasons. It would appear therefore that private patients

Table I. Type of surgery

	Ward	*Private*	*Total*
Curettage only	53 (45%)	175 (71%)	228
Abdominal hysterotomy and bilateral tubal ligation	41	36	77
Abdominal hysterectomy	19	8	27
Abdominal hysterotomy only	3	22	25
Curettage and bilateral tubal ligation	2	7	9

Table II. Indications in detail

	1951 through 1955		
	Ward	*Private*	*Total*
Psychiatric			
No specific diagnosis	4	37	41
Neurosis	0	21	21
Psychosis	8	44	52
	12 (14%)	102 (55%)	114
Cardiovascular			
Rheumatic	15	6	21
Hypertensive	12	5	17
Congenital	2	1	3
Other	1	0	1
	30	12	42
Pulmonary			
Tuberculosis	9	11	20
Asthma	0	2	2
Bronchiectasis	2	1	3
Sarcoidosis	1	0	1
Other	0	0	0
	12	14	26
Fetal			
Rubella	1	9	10
Rh incompatibility	0	6	6
Radiotherapy	2	0	2
Hereditary disease	1	2	3
	4	17	21
Oncological			
Breast	0	8	8
Other	2	3	5
	2	11	13
Neurological			
Multiple sclerosis	3	3	6
Brain tumor	1	0	1
Epilepsy	1	2	3
Other	4	2	6
	9	7	16
Renal			
Chronic nephritis	4	0	4
Other	0	3	3
	4	3	7
Other medical			
Arthritis	0	4	4
Lupus erythematosis	2	1	3
Colitis	1	2	3
Purpura	1	1	2
Liver disease	1	0	1
Esophageal varices	0	0	0
Diabetes	1	1	2
Otosclerosis	1	1	2
Previous toxemia	1	2	3
Recent surgery	1	2	3
Alcoholism	0	2	2
Ileitis	0	1	1
Amebic dysentery	0	1	1
Hyperemesis	0	1	1
Fibromyomas of the uterus	0	1	1
Ruptured intervertebral disc	0	1	1
Addison's disease	1	0	1
Dermatitis herpetiformis	1	0	1
Myasthenia gravis	0	0	0
Misdiagnosis	0	0	0
	11	21	32

1956 through 1960			1951 through 1960		
Ward	*Private*	*Total*	*Ward*	*Private*	*Total*
1	12	13	5	49	54
2	3	5	2	24	26
8	15	23	16	59	75
11 (33%)	30 (49%)	41	23 (19%)	132 (53%)	115
4	1	5	19	7	26
2	2	4	14	7	21
0	1	1	2	2	4
1	2	3	2	2	4
7	6	13	37	18	55
0	2	2	9	13	22
1	0	1	1	2	3
0	0	0	2	1	3
1	0	1	2	0	2
0	1	1	0	1	1
2	3	5	14	17	31
0	0	0	1	9	10
0	1	1	0	7	7
1	2	3	3	2	5
0	0	0	1	2	3
1	3	4	5	20	25
2	4	6	2	12	14
1	2	3	3	5	8
3	6	9	5	17	22
1	1	2	4	4	8
0	2	2	1	2	3
0	0	0	1	2	3
0	0	0	4	2	6
1	3	4	10	10	20
0	2	2	4	2	6
0	3	3	0	6	6
0	5	5	4	8	12
0	0	0	0	4	4
2	0	2	2	1	5
1	0	1	1	2	4
0	0	0	0	1	2
1	0	1	1	0	2
2	0	2	2	0	2
1	4	5	2	5	7
0	0	0	1	1	2
0	0	0	1	2	3
0	0	0	1	2	3
0	0	0	0	2	2
0	0	0	0	1	1
0	0	0	0	1	1
0	0	0	0	1	1
0	0	0	0	1	1
0	0	0	0	1	1
0	0	0	1	0	1
0	0	0	1	0	1
0	0	0	1	0	1
1	0	1	1	0	1
1	1	2	1	1	2
9	5	14	20	26	46

with unwanted pregnancies are more often referred for primary psychiatric evaluation and/or that psychiatric justification for abortion is more easily obtained for private patients.

But this is far from the complete explanation. As can be seen from Table II, abortions were more common among the private patients at Sloane Hospital for virtually all of the more debatable indications, such as arthritis, inactive tuberculosis, and rubella, and more common among the ward patients for most of the less debatable indications, such as rheumatic heart disease and hypertensive cardiovascular disease. Although comparably detailed information was not solicited from the 60 other hospitals, their participation in this trend is implied by their similar ward-private abortion ratios.

Further evidence of the greater liberality in the private abortion practice lies, of course, in the fact that at Sloane Hospital sterilizations accompanied abortions more than twice as often on the ward service whether the indication was psychiatric or medical.

The legality of therapeutic abortions. Today *the life of the mother* is almost never jeopardized by pregnancy, but *the mental and physical health of the mother and the proper development of the fetus* are not infrequently so jeopardized. Abortion is legally sanctioned by most states only if the former threat exists; yet abortion is medically approved and performed when the latter threats exist. The laws should be clarified to permit the indications for abortion which accepted medical practice has already legitimized.

The American Law Institute unanimously approved of a plan to liberalize our abortion laws 5 years ago. Nothing has been done to transform this proposal into legislation because no group has sought this action. Since it is the obstetricians who violate these laws, it is they, perhaps through their national societies, who should seek their renovation.

II. Sterilization

The sterilizations performed at Sloane Hospital were reviewed for the decade between Jan. 1, 1951, and Dec. 31, 1960. These procedures consisted of bilateral tubal ligations and cesarean hysterectomies. No attempt was made to determine which oophorectomies, salpingectomies, hysterectomies, or radiation castrations were performed for the primary purpose of sterilization, but this practice is uncommon at this hospital.

Table III. Sterilizations in association with therapeutic abortions

Indication for the abortion	*Ward*		*Private*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Psychiatric	7	30	18	14	25	16
Medical	55	58	33	28	88	42
Total	62	53	51	21	113	34

Table IV. Repeat therapeutic abortions during the study years

No. of patients	*No. of therapeutic abortions per patient*
1	3
7	2
2	2*
8	1*
2	1†

*Plus 1 more at Sloane Hospital or elsewhere prior to Sept. 1, 1950.

†Plus 2 more at Sloane Hospital or elsewhere prior to Sept. 1, 1950.

Incidence. The incidence of bilateral tubal ligations following vaginal deliveries of viable infants was as follows:

	Ward	*Private*	*Total*
A. No. of bilateral tubal ligations	464	137	601
B. No. of vaginal deliveries	24,406	12,120	36,526
Ratio of A:B	1:53	1:88	1:61

The incidence of sterilizations in association with cesarean sections was as follows:

	Ward	*Private*	*Total*
C. No. of bilateral tubal ligations	309	168	477
D. No. of cesarean hysterectomies	66	80	146

Table V. Legality of indications

Indication	Ward		Private	
	1951 through 1955	*1956 through 1960*	*1951 through 1955*	*1956 through 1960*
Group A				
Rubella	1	0	9	0
Rh incompatibility	0	0	6	1
Multiple sclerosis	3	1	3	1
Cancer, non-mammary	2	1	3	2
Arthritis	0	0	4	0
Epilepsy	1	0	2	0
Radiotherapy	2	1	0	2
Recent surgery	1	0	2	0
Alcoholism	0	0	2	0
Recurrent pyelitis	0	0	1	0
Asthma	0	0	2	0
Amebic dysentery	0	0	1	0
Brain tumor	1	0	0	2
Dermatitis herpetiformis	0	0	1	0
Liver disease	1	1	0	0
Anomalous children	1	0	0	0
Mental deficiency	1	0	0	0
Purpura	1	0	1	0
Otosclerosis	1	0	1	0
Diabetes	0	0	1	2
Misdiagnoses	0	1	0	1
Congenital cataracts	0	0	1	0
Fibroids	0	0	1	0
Ruptured intervertebral disc	0	0	1	0
Poliomyelitis	0	0	1	0
Previous nephrectomy	0	0	1	0
Totals	16	5	44	11
Group B				
Suicide attempt	0	0	2	0
Advanced tuberculosis	2	0	0	0
Chronic nephritis	4	0	0	1
Ureterosigmoidostomies	0	0	0	1
Severe rheumatic heart disease	3	0	2	1
Severe hypertensive disease	11	2	3	1
Expanding intracranial lesion	1	0	0	0
Intracranial aneurism	0	0	1	0
Severe congenital heart disease	0	1	1	0
Diabetes with renal damage	1	1	0	2
Totals	22	4	9	6

E. No. of cesarean sections	1,947	1,426	3,373
F. No. of nonprimary cesarean sections	866	681	1,547
Ratio of C + D:E	1:5	1:6	1:5
Ratio of C + D:F	1:2.3	1:2.7	1:2.5

The cumulative ratio of all postpartum sterilizations to all viable deliveries (A+C+D: B+E) was 1:31 or 3.2 per cent for the ward service, 1:35 or 2.9 per cent for the private service, and 1:33 or 3.0 per cent for both services.

Table VI. Incidence of ward and private therapeutic abortions at 60 hospitals

Years of report	*Institution*
1960-62	University of Iowa Hospitals
1961-62	Baylor University Medical Center, Dallas
1961-63	New York Hospital—Cornell
1960-61	Grace-New Haven Community Hospital
1960-62	University of California Hospital, San Francisco
1957-61	Johns Hopkins Hospital
1961-62	Pennsylvania Hospital
1959-62	University of Florida Hospital
1958-62	North Carolina Memorial Hospital
1961-62	Palo Alto-Stanford Hospital
6/62-5/63	St. Louis Maternity Hospital
1956-62	Providence Lying-In Hospital
1962	University of Maryland Hospital
1962	Michael Reese Hospital
1957-62	University of Mississippi Medical Center
1960-62	Woman's Hospital, New York City
1962	Albany Medical Center
1961	Medical College of Virginia Hospital
1962	Vanderbilt University Hospital
1/62-6/63	Syracuse Memorial Hospital
1956-61	Harper Hospital, Detroit
1962	Presbyterian Hospital, Denver
1962	Kapiolani Hospital, Honolulu
10/61-9/62	South Carolina Medical College Hospital
1961	Boston Lying-In Hospital
7/57-6/61	Strong Memorial Hospital, Rochester
1951-62	George Washington University Hospital
1951-62	Columbia Hospital for Women, Washington
1961-62	University of Vermont Hospitals
7/62-6/63	University of Virginia Hospital
1960-62	Ohio State University Hospital
1962-63	University of Wisconsin Hospitals
1962	University Hospitals of Cleveland
1953-62	University of Missouri Medical Center
1962	Presbyterian Medical Center, San Francisco
1962	Children's Hospital, San Francisco
1955-62	U. C. L. A. Medical Center, Los Angeles
1962	Hartford Hospital
7/60-6/61	University of Michigan Medical Center
1961-62	Evanston Hospital, Illinois
1960-62	Magee-Woman's Hospital, Pittsburgh
1962	Jackson Memorial Hospital, University of Miami
1958-62	St. Luke's Hospital, San Francisco
1962	West Virginia University Hospital
1962	University of Minnesota Hospital
	Totals
7/61-6/62	University of Illinois Research & Education Hospitals
1962	University of Nebraska Hospital
1957-62	Chicago Lying-In Hospital
1962	Louisville General Hospital
1957-62	Cincinnati General Hospital
1951-62	D. C. General Hospital, Washington
1962	Jefferson Davis Hospital, Houston
1961	Eugene Talmadge Hospital, Augusta
7/52-6/62	University of Colorado Medical Center
1/60-6/63	University of Oregon Medical Center
	Totals
1961-62	Mayo Clinic
1953-62	The California Hospital, Los Angeles
1962	Henry Ford Hospital, Detroit
7/62-6/63	Swedish Hospital, Seattle
1961	St. Luke's Episcopal Hospital, Houston
	Totals
	Grand totals

Ward			Private		
No. of deliveries	*Abortions*	*Abortions: deliveries*	*No. of deliveries*	*Abortions*	*Abortions: deliveries*
4,606	3	1:1,535	1,536	7	1:219
878	1	1:878	14,985	22	1:681
7,314	6	1:1,219	6,973	15	1:465
2,676	5	1:535	7,674	31	1:248
4,852	16	1:303	1,272	15	1:85
11,358	20	1:568	6,046	25	1:242
2,793	4	1:698	3,246	25	1:130
2,388	2	1:1,194	483	6	1:80
4,346	10	1:435	2,125	11	1:193
782	5	1:156	5,172	52	1:99
1,127	1	1:1,127	1,402	2	1:702
7,083	0	0:7,083	45,775	11	1:4,161
2,381	0	0:2,381	538	0	0:538
1,371	1	1:1,371	1,560	10	1:156
8,678	2	1:4,339	736	5	1:147
4,501	5	1:900	2,023	101	1:20
552	0	0:552	1,857	1	1:1,857
4,529	3	1:1,510	1,455	2	1:728
793	0	0:793	393	1	1:393
606	0	0:606	3,800	3	1:1,267
2,595	0	0:2.595	11,051	3	1:3,684
423	0	0:423	1,895	5	1:379
390	1	1:390	4,092	3	1:1,364
2,147	0	0:2,147	208	0	0:208
2,181	8	1:273	3,926	24	1:164
4,765	2	1:2,383	5,824	13	1:448
4,324	1	1:4,324	38,917	178	1:218
1,345	0	0:1,345	3,756	30	1:125
677	1	1:677	3,900	7	1:557
1,535	0	0:1,535	529	0	0:529
7,360	2	1:3,680	3,927	4	1:982
275	2	1:138	207	0	0:207
1,618	8	1:202	2,526	19	1:133
2,388	1	1:2,388	724	0	0:724
241	0	0:241	613	17	1:36
286	0	0:286	1,719	20	1:86
6,634	20	1:332	2,951	36	1:82
621	0	0:621	4,886	18	1:271
1,086	0	0:1,086	373	0	0:373
373	0	0:373	3,944	4	1:986
4,666	2	1:2,333	13,152	15	1:877
3,361	0	0:3,361	1,242	3	1:414
1,773	0	0:1,773	5,383	9	1:598
302	1	1:302	308	0	0:308
720	0	0:720	120	0	0:120
125,700	**133**	**1:945**	**225,700**	**753**	**1:300**
2,500	2	1:1,250			
908	0	0:908			
14,332	63	1:227			
2,831	0	0:2,831			
24,417	0	0:24,417			
71,705	5	1:14,341			
6,500	0	0:6,500			
1,041	0	0:1,041			
13,563	24	1:565			
5,429	7	1:776			
143,226	**101**	**1:1,417**			
			3,439	5	1:688
			17,911	40	1:488
			1,300	4	1:325
			2,786	3	1:927
			2,969	0	0:2,969
			28,405	**52**	**1:546**
268,926	**234**	**1:1,149**	**253,652**	**805**	**1:315**

Table VII. Incidence of therapeutic abortions at various types of hospitals in New York City, 1957-1960[1]

Type of hospital	*Ratio of therapeutic abortions to live births*
Proprietary	1:204
Voluntary, private service	1:417
Voluntary, ward service	1:1,667
Municipal	1:5,000

Table VIII. Indications for postpartum and postabortal sterilizations

	No. of ward cases	*No. of private cases*	*Total No. of cases*
Category 1 (slight medical disease)			
Rh or ABO incompatibility	9	9	18
Emotional disturbance	9	8	17
Varicose veins	2	6	8
Habitual abortions	5	1	6
Moderate hypertension	3	0	3
Sickle cell trait	2	0	2
Recurrent toxemia	2	0	2
Recurrent hyperemesis	1	0	1
Recurrent delivery complications	1	0	1
Liver disease	1	0	1
Syphilis	1	0	1
Neurodermatitis	1	0	1
Tuberculosis, husband	1	0	1
Cataracts	0	1	1
Arrested tuberculosis	0	1	1
Category 2 (serious medical disease)			
Heart disease	22	5	27
Severe hypertension	26	1	27
Rh sensitization	12	7	19
Diabetes	8	2	10
Renal disease	8	2	10
Psychosis	9	0	9
Active tuberculosis	7	0	7
Thrombophlebitis	3	4	7
Familial diseases	3	3	6
Epilepsy	3	2	5
Sickle cell anemia	3	0	3
Intracranial aneurism	2	0	2
Addison's disease	2	0	2
Multiple sclerosis	2	0	2
Asthma	2	0	2
Miscellaneous	14	1	15
Category 3 (parity in excess of 4)	302	36	338
Category 4 (no medical disease; parity less than 5)	7	54	61

In addition to the postpartum sterilizations there were the following:

	Ward	*Private*	*Total*
G. Bilateral tubal ligations following spontaneous abortions	9	6	15
H. Bilateral tubal ligations at laparotomy for ectopic pregnancies	2	0	2
I. Bilateral tubal ligations with therapeutic abortions	62	51	113
J. Interval tubal ligations	59	39	98

The yearly incidence of sterilizations between 1951 and 1960 remained remarkably constant for all of the above categories except for the interval sterilizations on the ward service, 66 per cent of which were performed during the last three years of the study period.

Since the subjects of postpartum and interval sterilizations are slightly different, they will be discussed separately.

Puerperal sterilizations.

Case material. The following data pertain to the patients in Categories A and G above. The cases of sterilization associated with cesarean sections were not analyzed in detail.

Two hundred and forty-two of the ward patients were Negro, one was Oriental, and 230 were Caucasian. This Caucasian:Negro ratio of 0.95:1 is considerably lower than the 1.4:1 ratio for the entire ward obstetrical service. Of the private patients, three were Negro and 140 Caucasian.

Excluding the Negroes and Puerto Ricans, 69 per cent of the 163 remaining ward patients and 25 per cent of the remaining 138 private patients were Catholic.

The average age of the ward patients was 32.2 years; of the private patients, 33.7. Thirty-one per cent of the ward patients were under the age of 30, as opposed to 14 per cent of the private patients.

*Indications.** For the purpose of analytic simplification, the indications for postpartum

*Generally speaking, postpartum sterilization is permissible at Sloane Hospital for medical indications, repeat cesarean sections, and parity in excess of four.[3]

and postabortal sterilizations were grouped into the four categories shown in Table VIII. The relative frequency of these various categories is outlined in Table IX. Fifty-four per cent of the private cases and 6 per cent of the ward cases fell into Category 1 (slight medical disease) or Category 4 (no medical disease, parity less than 5). Moreover, the parity of the private patients in Categories 1 and 4 was three or less in 49 per cent (25 patients were para iii, 13 were para ii, one was para i), whereas the parity of the ward patients was three (never less) in only 13 per cent (6 patients).

Parity. The average parity of the ward patients was 6.1, and of the private patients 3.8.

Experience at other hospitals. Of the 65 hospitals in the survey, useful information about postpartum sterilizations was received from the 53 listed in Table X. Since it was unclear from some of the replies whether sterilizations at the time of cesarean sections and abortions were included among the data submitted, it is probably reasonable to assume that the actual incidence of postpartum sterilization is slightly higher than that shown by this table. Although the range from one sterilization per eleven deliveries to one per 467 deliveries on the ward services and from 1:10 to 1:483 on the private services is wide, the over-all minimum average incidence of 2.5 per cent (10,075 sterilizations among 409,374 deliveries, including the Sloane Hospital figures) is probably fairly accurate.

The ward and private rates in this series (including the Sloane Hospital figures) were 2.4 per cent and 2.2 per cent respectively. A similar survey by Starr and Kosasky[9] of 5,673 puerperal sterilizations among 177,433 live births revealed a ward rate of 3.0 per cent and a private rate of 3.3 per cent. These sets of incidence figures are generally in keeping with those reported elsewhere.[10-14]

Comment.

1. The ward-private ratio of puerperal sterilizations. The fact that the ward and private sterilization rates are virtually identical is deceptive, for it suggests the incorrect conclusion that ward and private patients are sterilized in accordance with similar standards. That a double standard does actually pertain to the practice of sterilization as well as abortion is indicated in part by the fact that the average parity of the ward and private patients sterilized at Sloane Hospital was 6.1 and 3.8, respectively, and the medical indications for these sterilizations were debatable in 54 per cent of the private cases and only 6 per cent of the ward cases. There is no reason to believe that similar disparities do not prevail at other hospitals.

2. The legality of sterilizations. There are two states (Virginia and North Carolina) which have recently enacted laws permitting sterilization for any reason considered sufficient by two physicians and specifically protecting these doctors from legal redress. These laws are not ideal. In the first place they require a thirty-day waiting period between patient permission and medical action, thus rendering postpartum sterilization practically impossible for the late antepartum registrant. Secondly, they require hospitalization of the patient, thus complicating the simple office procedure of vasectomy. Thirdly, and perhaps worst of all, the very existence of these laws in two states has led many of the physicians in the other 48 states to fear that they should be similarly protected in order to perform a sterilizing procedure.

What is the need for such laws? There is no legal precedent to support the physician's fear that freely requested and medically sanc-

Table IX. Frequency of indications for postpartum and postabortal sterilizations

	Ward	*Private*	*Total*
Category 1			
Parity of 4 or less	23	23	46
Parity of 5 or more*	15	3	18
Category 2			
Parity of 4 or less	76	23	99
Parity of 5 or more*	50	4	54
Category 3*	302	36	338
Category 4	7 (1.5%)	54 (38%)	61

*Total with parity of 5 or more was 410; 367 (78 per cent) were ward and 43 (30 per cent) were private patients.

Table X. Incidence of ward and private postpartum sterilizations in 53 hospitals

Years of report	Institution	Ward			Private		
		No. of deliveries	No. of sterilizations	Sterilizations: deliveries	No. of deliveries	No. of sterilizations	Sterilizations: deliveries
1961-62	Baylor University Medical Center, Dallas	878	11	1:80	14,985	719	1:21
1960-61	Grace-New Haven Community Hospital	2,676	57	1:47	7,674	135	1:56
1960-62	University of California Hospital, San Francisco	4,852	177	1:27	1,272	31	1:36
1957-61	Johns Hopkins Hospital	11,358	538	1:21	6,046	72	1:84
1961-62	Pennsylvania Hospital	2,793	71	1:39	3,246	121	1:27
1959-62	University of Florida Hospital	2,388	44	1:22	482	1	1:483
1958-62	North Carolina Memorial Hospital	4,346	43	1:101	2,125	16	1:133
1961-62	Palo Alto-Stanford Hospital	782	29	1:27	5,172	130	1:40
6/62-5/63	Washington University Hospital, St. Louis	1,127	30	1:38	1,402	39	1:36
1956-62	Providence Lying-In Hospital	7,083	91	1:78	45,775	316	1:145
1962	University of Maryland Hospital	2,381	39	1:61	538	42	1:13
1962	Michael Reese Hospital	1,371	50	1:37	1,560	31	1:50
1960-62	Woman's Hospital-St. Luke's	4,501	182	1:25	2,023	74	1:27
1962	Albany Medical Center	552	4	1:138	1,857	10	1:186
1961	Medical College of Virginia Hospital	4,529	403	1:11	1,455	80	1:18
1962	Vanderbilt University Hospital	793	71	1:11	393	39	1:10
1/62-6/63	Syracuse Memorial Hospital	606	0	0:606	3,800	24	1:158
1956-61	Harper Hospital, Detroit	2,595	97	1:27	11,051	264	1:42
1962	Presbyterian Hospital, Denver	423	14	1:30	1,895	127	1:15
1962	Kapiolani Hospital, Honolulu	390	22	1:16	4,092	236	1:17
10/61-9/62	South Carolina Medical College Hospital	2,147	51	1:42	208	8	1:26
1961	Boston Lying-In Hospital	2,181	47	1:46	3,926	105	1:37
7/57-6/61	Strong Memorial Hospital, Rochester	4,765	46	1:104	5,824	72	1:64
1961-62	University of Vermont Hospitals	677	39	1:17	3,900	83	1:47
7/62-6/63	University of Virginia Hospital	1,535	85	1:18	529	10	1:53
1962-63	University of Wisconsin Hospitals	275	5	1:55	207	3	1:69
1962	University Hospitals of Cleveland	1,618	28	1:58	2,526	104	1:24
1962	Presbyterian Medical Center, San Francisco	241	8	1:30	613	16	1:38
1962	Children's Hospital, San Francisco	286	9	1:32	1,719	30	1:57
1955-62	U. C. L. A. Medical Center, Los Angeles	6,634	82	1:81	2,951	40	1:74
1962	Hartford Hospital	621	8	1:78	4,886	83	1:59
7/60-6/61	University of Michigan Medical Center	1,086	11	1:99	373	3	1:126

Table X. Cont'd

Years of report	Institution	Ward			Private		
		No. of deliveries	No. of sterilizations	Sterilizations: deliveries	No. of deliveries	No. of sterilizations	Sterilizations: deliveries
1960-62	Ohio State University Hospital	7,360	294	1:25	3,927	240	1:16
1961-62	Evanston Hospital	373	19	1:20	3,944	163	1:24
1960-62	Magee-Woman's Hospital, Pittsburgh	4,666	10	1:467	13,152	226	1:58
1962	Jackson Memorial Hospital, Miami	3,361	12	1:280	1,242	15	1:83
1958-62	St. Luke's Hospital, San Francisco	1,773	19	1:93	5,383	77	1:70
1962	West Virginia University Hospital	302	15	1:20	308	7	1:44
1962	University of Minnesota Hospital	720	15	1:48	120	1	1:120
	Totals	96,967	2,776	1:35 (2.9%)	172,582	3,793	1:45 (2.2%)
7/61-6/62	University of Illinois Research & Education Hospitals	2,500	41	1:61			
1962	University of Nebraska Hospital	908	29	1:31			
1957-62	Chicago Lying-In Hospital	14,332	617	1:64			
1962	Louisville General Hospital	2,831	55	1:51			
1957-62	Cincinnati General Hospital	24,417	235	1:104			
1962	Jefferson Davis Hospital, Houston	6,500	262	1:25			
1961	Eugene Talmadge Hospital, Augusta	1,041	19	1:55			
7/52-6/62	University of Colorado Medical Center	13,563	225	1:60			
1/60-6/63	University of Oregon Medical Center	5,429	224	1:24			
	Totals	71,521	1,707	1:42 (2.4%)			
1961-62	Mayo Clinic				3,439	26	1:132
1953-62	The California Hospital, Los Angeles				17,911	294	1:448
7/62-6/63	Swedish Hospital, Seattle				2,786	113	1:25
1961	St. Luke's Episcopal Hospital, Houston				2,969	111	1:27
1962	Henry Ford Hospital, Detroit				1,300	31	1:42
	Totals				28,405	575	1:49 (2.0%)
	Grand totals	168,488	4,483	1:38 (2.6%)	200,987	4,368	1:46 (2.2%)

tioned sterilization procedures are forensically indefensible. As a matter of fact, in the only sterilization case ever tried on medical grounds in a United States' court it was held that [even] vasectomy does not constitute mayhem.[15]

Once again, since this is primarily an obstetrical issue, it should be resolved by obstetricians. With or without the formality of legislation, some representative body of obstetricians should establish an acceptable code of sterilization ethics.

Interval sterilizations.

Incidence. At Sloane Hospital during the years of 1951 through 1960 there were 59 interval sterilizations on the ward service

and 39 on the private service. One such procedure was performed for every 448 ward deliveries and for every 351 private deliveries. This ratio is of course less meaningful for this particular type of operation, but it is the only parameter available by which the frequency of this practice can be measured.

Case material. Forty-five of the 59 ward patients were Caucasian, 13 were Negro, and one was Oriental. All of the 39 private patients in this group were Caucasian.

Excluding the Negroes and Puerto Ricans, 75 per cent of the 24 remaining ward patients and 21 per cent of the 39 private patients were Catholic.

Fifty-three (90 per cent) of the ward patients lived in New York City; the remaining 6 lived elsewhere in New York State. Twelve (31 per cent) of the private patients lived in New York City, 11 elsewhere in New York State, and 16 in some other state.

The average age of the ward patients was 33.2 and of the private patients 34.0 years.

The average parity of the ward patients was 4.3, of the private patients 3.0.

Type of surgery. All of the sterilizations in this group were accomplished by bilateral tubal ligation. The approach to the tubes (whether abdominal or vaginal) and the nature of coincidental surgery (abdominal or vaginal), if any, are given in Table XI.

Indications. The various indications for which these sterilizations were done is shown in Table XII and the relative frequency of these five categories in Table XIII. Forty-nine per cent of the private cases and 8 per cent of the ward cases fell into Category 1 (slight medical disease) or Category 4 (no medical disease, parity less than 5).

Experience at other hospitals. Accurate data on the practice of interval sterilizations are difficult to obtain. The survey of 65 hospitals yielded the following: 34 hospitals reported 647 ward interval sterilizations and

Table XI. Surgical approach for interval sterilizations

Approach to sterilization	*Approach to coincidental surgery, if any*	*Ward*	*Private*	*Total*
Abdominal	None	11	16	27
Abdominal	Abdominal	1	10	11
Abdominal	Vaginal	11	6	17
Vaginal	None	15	0	15
Vaginal	Vaginal	21	7	28

Table XII. Indications for interval sterilizations

	No. of ward cases	*No. of private cases*	*Total No. of cases*
Category 1 (slight medical disease)			
Arrested tuberculosis	2	0	2
Varicose veins	0	2	2
Recurrent pyelonephritis	0	1	1
Muscular dystrophy, husband	0	1	1
Cerebral spasm with last pregnancy	0	1	1
Recent spinal fusion	1	1	2
Previous postpartum depression	0	1	1
Cervical amputation for leukorrhea	0	1	1
Neurosis	0	1	1
Habitual abortions	0	1	1
Moderate hypertension	1	0	1
Pachyonychia congenita	1	0	1
Mental depression	1	0	1
Category 2 (serious medical disease)			
Asthma	3	0	3
Heart disease	1	0	1
Psychosis	1	0	1
Ruptured intervertebral disc	1	0	1
Rheumatoid arthritis	1	0	1
Hereditary C. N. S. lesion	1	0	1
Postconcussion syndrome	0	1	1
Postpartum psychosis	0	1	1
Active tuberculosis	0	1	1
Category 3 (parity in excess of 4)	12	3	15
Category 4 (no medical disease, parity less than 5)	1	11	12
Category 5 (coincidental colporrhaphy)	32	12	44

XIII. Frequency of indications for interval sterilizations

	No. of ward cases	*No. of private cases*	*No. of cases*
Category 1			
Parity of 4 or less	4	8	12
Parity of 5 or more*	2	2	4
Category 2			
Parity of 4 or less	4	3	7
Parity of 5 or more*	4	0	4
Category 3*	12	3	15
Category 4	1	11	12
Category 5			
Parity of 4 or less	23	11	34
Parity of 5 or more*	9	1	10

*Total number with parity of 5 or more was 33; 27 (46 per cent) were ward and 6 (15 per cent) were private patients.

Table XIV. Frequency of contraceptive advice given to the ward patients of 55 hospitals

	No. of hospitals
Unknown	18
None	13
Less than 26 per cent	9
26 to 50 per cent	10
51 to 75 per cent	2
More than 75 per cent	3

102,849 ward deliveries, a ratio of 1:159; and 27 hospitals reported 595 private interval sterilizations and 126,674 private deliveries, a ratio of 1:213.

Comment. It is generally believed that tubal ligations should be performed almost exclusively in the puerperium. Hence, only 7 per cent of the sterilizations in the Sloane Hospital series were done on an interval basis, 35 per cent of these were done in conjunction with a colporrhaphy, and 21 per cent were done within 6 months of delivery. This belief needs reappraisal. Why should a patient be denied sterilization just because her youngest child is 2 years instead of 2 days old?

III. Contraception

Precise information with regard to the number of Sloane Hospital private and ward patients who have obtained contraceptive advice is unavailable. One approximate fact is known: about 275 new ward patients were seen in the contraceptive clinic every year between 1951 and 1960 and, hence, about 2,750 during the decade. Since there were 29,286 ward deliveries during these years, approximately 9.4 per cent of the ward patients received contraceptive advice. On the other hand, a poll of the attending physicians reveals that contraceptive advice was made available to all of the private patients who wanted it.

Experience at other hospitals. Precise data on the availability of contraceptive advice were also impossible to obtain from the 65 hospitals surveyed. The approximate calculations submitted from the ward services of 55 hospitals are shown in Table XIV. Of the 37 hospitals which estimated the incidence of giving contraceptive advice to their ward patients, 13 reported no contraceptive service, 19 reported an estimate of less than 50 per cent, and five an estimate of more than 50 per cent. Yet it must be safe to assume that contraceptive advice was available to virtually all of the private patients who wanted it.

Comment. The American College of Obstetricians and Gynecologists has already officially approved the principle of providing contraception to all who desire it. It now devolves upon the obstetricians of this country to convert this principle into fact.

Conclusion

The institution and implementation of birth control measures are primarily medical matters. The obstetrician's obligation to provide abortion, sterilization, and contraception is inadequately and inequitably met at the moment. The obstetricians of America must individually and collectively review these vital issues in an effort to establish a more uniformly humane birth control ethic.

REFERENCES

1. Gold, E. M.: Personal communication.
2. Tietze, C: Am. J. Obst. & Gynec. 60: 146, 1950.
3. Gebhard, P. H., Pomeroy, W. B., Martin, C. E., and Christenson, C. V.: Pregnancy, Birth, and Abortion, New York, 1958, Harper & Bros, and Paul B. Hoeber, Inc., p. 196.
4. Kleegman, S. J.: *In* Rosen, H., editor: Therapeutic Abortion, New York, 1954, Julian Press, Inc., p. 254.
5. Erhardt, C.: *In* Calderone, M. S., editor: Abortion in the United States, New York, 1958, Paul B. Hoeber, Inc., p. 77.
6. Mandy, A. J.: *In* Rosen, H., editor: Therapeutic Abortion, New York, 1954, Julian Press, Inc., p. 284.
7. Guttmacher, A. F.: Surg. Clin. North America 37: 459, 1957.
8. D'Esopo, D. A.: Bull. Sloane Hosp. for Women 7: 134, 1961.
9. Starr, S. H., and Kosasky, H. J.: Am. J. Obst. & Gynec. 88: 944, 1964.
10. August R. V.: Obst. & Gynec. 5: 715, 1955.
11. Savel, L. E., and Perlmutter, I. K.: Am. J. Obst. & Gynec. 80: 1192, 1960.
12. Lull, C. B., and Mitchell, R. M.: Am. J. Obst. & Gynec. 59: 1118, 1950.
13. Barnes, A. C., and Zuspan, F. P.: Am. J. Obst. & Gynec. 75: 65, 1958.
14. Prystowsky, H., and Eastman, N. J.: J. A. M. A. 158: 463, 1955.
15. Christensen versus Thornby, 255, N. W. 620 (Minnesota 1934).

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Therapeutic abortion follow-up study

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A heterogeneous group of pregnant women petitioned for abortion because of possible impairment of mental and/or physical health; 43 of 50 were followed for 3 to 6 months. Ambivalence and guilt appeared more substantially in young women under 18 years of age. Three to 6 months afterward, 29 patients expressed a positive reaction toward abortion, 10 reported no significant change in their life situations and 4 responded negatively. Of the 41 patients remaining fertile, 4 had purposely become pregnant again; 8 others were apparently without consistent contraception. It was concluded that preabortion counseling should outline the necessary steps for Committee consideration, give reassurance as to physical safety, and help the patient understand her motives and goals. Postabortion follow-up should emphasize a clear contraceptive program.

INDUCED ABORTION has become a major method of birth control in many parts of the world. Throughout the United States in the past 3 years, there have been significant modifications of a number of restrictive state abortion laws. Sloane's[1] recent review summarizes the current medical and social dilemma over this problem and concludes that psychiatric labels often mask humanitarian reasons for bortions.

After the 1967 abortion law revision in California, there was a rapid evolution in this field. With the ensuing increase in legal abortions, it became possible to study prospectively a heterogeneous group of women who desired abortions for a variety of reasons. This is a preliminary report on the follow-up of such a study group.

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Presented at the Thirty-seventh Annual Meeting of the Pafific Coast Obstetrical and Gynecological Society, Kauai, Hawaii, November 9-14, 1970.

Patients and procedures

From November 1, 1967, to June 30, 1968, 55 women applied to the staff of the Obstetrical Service of the University of California–San Francisco for termination of pregnancy because of its possible significant impairment of their mental or physical health. The screening procedures used in this study included: (1) a self-administered questionnaire* at the time of initial application for abortion, which provided demographic data and pertinent information; (2) a Minnesota Multiphasic Personality Inventory (MMPI) profile prior to abortion and again 3 to 6 months later (this test was omitted when cultural or linguistic factors obviated its use); (3) a psychiatric evaluation of the degree of psychiatric illness and/or possible effects of pregnancy on the patient's mental health; (4) a semistructured interview* by a social worker (adapted from Simon and associates[2]) 3 to 6 months after the abortion to

*Available on request to Dr. Davison, Adult Psychiatric Clinic, University of California–San Francisco, San Francisco, California 94122.

Table I. Therapeutic abortion committee results (Novemeber, 1967, to June, 1968)

Total No. of patients considered	55
Abortion refused	4
3 aborted elsewhere	
1 delivered twins at term, had tubal ligation	
Abortion granted	51
6 medical indications	
44 psychiatric indications	
1 refused and went to term	
Follow-up	
Complete	43
Incomplete	7

assess the postabortal responses and psychosocial situation.

The abortion techniques included dilatation and curettage in early weeks of pregnancy (in 2 women), aspiration (in 29), hypertonic injection (in 9), and hysterotomy (in 1). At the patients' own request, tubal ligation was also done in 4 who had aspiration abortion, in one with hypertonic injection, and in one with hysterotomy; 3 also had hysterectomies.

Results

The Therapeutic Abortion Committee (Table I) accepted 51 of the 55 women who applied, one of whom subsequently elected to carry her pregnancy to term. Three were rejected on the basis of insufficient evidence to substantiate impairment of mental health and obtained abortions elsewhere. A fourth patient, who was rejected because abortion seemed psychiatrically contraindicated, was delivered of twins at term and had a tubal ligation.

Information accrued (Table II) from the self-administered questionnaire showed a wide age range—from 13 to 44 years, with 46 per cent of patients falling between 21 and 26 years. Thirty-six were in the first trimester at the time of abortion, despite the 10 to 14 day preabortion procedures. The psychiatric evaluations at the time of approval included 15 with a situational reaction, 14 with neurosis, 10 with character disorders, 6 who had a major psychotic illness

Table II. Demographic data on 51 patients

Age (years)	
13-14	3
15-19	6
20-24	19
25-29	8
30-34	7
35-39	2
40 and over	6
Marital status	
Never married	23
Married or common-law relationship	21
Separated, divorced, or widowed	7
Race	
Caucasian	41
Negro	7
Filipino	2
Oriental	1
Education	
Below high school graduate	11
High school graduate	14
Some college	26
Income (self or family)	
$10,000 or more	8
5,000-10,000	13
3,000 - 5,000	12
3,000 or less, and welfare	13
Unknown	5
Patient status	
Private	15
Staff	36
Prior pregnancies	
None	19
Term or premature delivery	25
Spontaneous abortion only	1
Induced abortion	6
Present pregnancy (weeks' gestation)	
6-9	6
10-13	30
14-20	15
Contraception	
None or irregular	21
Rhythm, douche	4
Withdrawal, Foam	7
Condom, diaphragm	6
Intrauterine device	3
Oral contraceptive	9
Unknown	1
Prior sociopsychiatric assistance	
None	24
Individual psychotherapy	21
Hospital or day care	4
Group therapy	1
Social work interviews	1

Table III. Pregnancies following therapeutic abortion

Age	*Marital status*	*Prior pregnancies*	*Indications for abortion*	*Months to conception following abortions*	*Comments*
26	Common-law relationship	2 Illegal abortions	Mental health	5 months	Conceived intentionally in same relationship that prompted therapeutic abortion; now felt more secure and continued pregnancy.
26	Married	2 Term deliveries 1 Spontaneous abortion	Recurrent sarcoma	2 months	Regretful that abortion and chemotherapy did not influence extensive sarcoma; continued pregnancy.
22	Common-law relationship	1 Term delivery 2 Illegal abortions	Mental health	6 months	Therapeutic abortion for pregnancy by undetermined father; currently pregnant by man whom she has married; continued pregnancy.
16	Single	None	Mental health	2 months	Felt forced to abortion by family; conceived again and continued pregnancy.

concurrent with the pregnancy or in the immediate past, and 6 who had no obvious psychiatric problems.

Four to 6 months after abortion, the follow-up interview on 43 patients indicated that 22 had positive psychological changes, demonstrated by growth experience, increased empathy, increased sense of freedom, and greater sense of femininity. Seven reported other positive changes, such as less fear of pregnancy assured by sterilization or knowledge of better birth control methods, and improved marital or family relations. Four had negative reactions, such as guilt or fear of men, and 10 indicated no change in attitude.

The patients' principal fears of abortion were concerned with the possibility of injury as a result of the abortion technique (in 21 women), its effect on mental or physical health (in 6), retaliation by others or by one's own conscience (in 5), feelings about destroying living tissue (in 3), and Committee rejection (for 2). In the postabortion follow-up, 36 expressed negative reactions centered around the ignorance of the procedural technicalities (in 12), the time required for processing (in 13), and some apparently embarrassing personal encounters during the experience (in 11). The 25 positive responses indicated good supportive help from various staff members. The principal suggestion by the patients was a request for more available public information and less complex application requirements.

Of the 41 aborted women who were not sterilized, 4 became pregnant again (Table III). In each case the pregnancy was consciously sought for a variety of reasons. In 2, the abortion was a regretful experience, while in the other 2 the abortion seemed to have allowed more stable life situations to become manifest. In addition to the 16 year old, who was pregnant again, a 13 year old and a 14 year old also regretted their preabortion decisions; all three felt very guilty and believed they had injured a living being.

The mean preabortion MMPI showed abnormal elevations on the scales depicting depression, psychopathic deviation, and schizophrenia. A study of 36 paired pre- and post-abortion profiles showed that 15 of the 27 initially abnormal tests became essentially normal after abortion. This was a significant change ($P < 0.002$) by a test for correlated proportions.

In response to several questions designed to detect mixtures of feelings, 17 of those responding reported some guilt, and 20 had some ambivalence. Nevertheless, in a direct query as to whether they would repeat the abortion under similar circumstances,

Table IV. Recent therapeutic abortion follow-up studies within the United States

Source of data	*Years of study*	*Sample size studied*	*Total group aborted*	*Age (mean or range)*
Peck and Marcus,[3] Mt. Sinai Hospital, New York	1963 to 1665	50	85	20-40
Simon and associates,[2] Jewish Hospital of St. Louis	1955 to 1964	46	65	Not stated
Patt and colleagues,[4] Michael Reese Hospital, Chicago	1964 to 1968	35	48	23
Levene and Rigney,[5] San Francisco	1968	56	70	21
This study	1968	43	50	13-44

37 said they would, 6 were unsure, and 2 would have refused.

In contrast to the generally poor preabortion contraceptive practices, 25 patients were taking oral birth control pills 3 to 6 months after abortion. Two patients were satisfied with IUD's, and one patient used a diaphragm, and one used a condom. Six patients refused birth control advice, and 6 patients did not return for a postabortal doctor visit.

After therapeutic abortion, 3 patients initiated psychotherapy, and 11 continued psychiatric care, while 6 had short-term, problem-directed interviews with a psychiatrist or social worker. Twenty-three women had no sociopsychiatric follow-up observation beyond the tests made to complete this study.

Comment

Our data corroborate 4 recent studies of therapeutic abortion patients in the United States (Table IV), which show that terminations of pregnancy do not tend to aggravate mental illness and are often helpful to the life situation adjustment of these patients. The legal, social, and medical sanction for interruption of pregnancy results in minimizing untoward guilt and depressive reactions, leaving the great majority of women with a sense of rightness of their pregnancy terminations, now culturally approved.

Of particular concern to us, however, are the pregnant girls under 18. Although our study group was small, we encountered a great deal of ambivalence and guilt. As a result, we feel that especially careful evaluation and counseling should be provided for them and their families. The alternative of a teen-ager carrying a pregnancy to term presents great difficulties for the teen-ager and her child, and the delicate balancing of risks often requires the most expert collaborative effort of physician, psychiatrist, and social worker.

A large number of patients used oral contraceptives regularly after abortion; however, 8 women were apparently without satisfactory birth control advice 3 to 6 months afterward. Although they were not pregnant, they constitute a significant group of potential repeaters. It is mandatory that a therapeutic abortion unit place a high priority on understanding the patient's attitude toward birth control and help her to choose a method which she will use regularly.

The things that concerned our patients most about abortion were ignorance of what to expect in the preliminary screening process and fear of the physical danger of the

Marital status	*Socioeconomic status*	*Indication for abortion*	*General impression of outcome*
Mostly married	Caucasian Jewish private patients	25 Psych. 25 Nonpsych.	"The psychiatric status of 92 per cent . . . improved or unchanged. . . ." "Ninety-eight per cent . . . would . . . with hindsight . . . again elect abortion in perference to continuing pregnancy in question."
Not stated	Well-educated Caucasian Protestant or Jewish patients	16 Psych. 30 Nonpsych.	"Little new psychiatric illness . . . that could be related to abortion."
23 Unmarried 12 Married	31 Private patients 4 Staff service	35 Psych.	". . . with rare exceptions, abortion was genuinely therapeutic."
59 Unmarried 11 Married	70 Private patients	70 Psych.	"Properly done induced abortion does not in itself result in significantly noxious emotional sequelae."
22 Unmarried 21 Married 7 Separated	15 Private patients 36 Staff service	44 Psych. 6 Nonpsych.	29 patients expressed positive reaction after abortion; 10 reported no significant change; 4 responded negatively.

surgical procedure. Both of these areas should be emphasized in the preabortion counseling, as well as the fact that few requests for therapeutic termination are denied. Concerns over time schedule or anonynity can quickly be dispelled. The conflicting feelings arising from conscience or fear of family repercussions can be pinpointed for more intensive follow-up.

As a result of our study, we have tried to shorten the time between patient application, Committee decision, and abortion, as well as to minimize cost and provide efficient, effective care by come-and-go abortion procedures in the first trimester. At present, the time interval from first contact to abortion ranges from 36 hours to 2 weeks.

Since California law and others modeled on American Law Institute recommendations do not specify that a psychiatrist must attest to the degree of mental health impairment of the patient, we have encouraged the patient's physician to make that assessment. If a psychological problem is unresolved, or if the patient is grossly disturbed, a psychiatric consultation is obviously important. However, an interested and concerned obstetrician can usually make the necessary observations to permit a final judgment by the Committee. Currently, a formal psychiatric consultation is presented to the Committee in 10 per cent of the staff cases and in 20 per cent of the private cases.

For many women, therapeutic abortion will become an increasingly frequent alternate to a stressful pregnancy. An estimated 60,000 abortions will have been done in California during 1970. Such a procedure must continue to be carefully scrutinized so that it will be associated with minimal hazards and maximum efficiency and effectiveness.

REFERENCES

1. Sloane, R. B.: New Eng. J. Med. 280: 1206, 1969.
2. Simon, N. M., Senturia, A. G., and Rothman, D.: Amer. J. Psychiat. 124: 59, 1967.
3. Peck, A., and Marcus, H.: J. Nerv. Ment. Dis. 143: 417, 1966.
4. Patt, S. L., Rappaport, R. G., and Barglow, P.: Arch. Gen. Psychiat. 20: 408, 1969.
5. Levene, H., and Rigney, F.: J. Nerv. Ment. Dis. 151: 51, 1970.

Discussion

Dr. John C. McDermott, San Mateo, California. Dr. Margolis, along with many others, recognizes that abortion is not a simple matter and that problems other than morbidity and deaths are involved. He has attempted a prospective study for which he should be commended but to believe that observations over the 6 month postabortal period are of much importance is to give them more weight than they deserve. While anecdotal discussion is derogated by our scientific colleagues, my thoughts go back to the time I started private practice in 1936. During the great depression, abortions were as popular as they are today. At that time, most abortions were done by experts, since staying out of San Quentin was a strong incentive. They were also done early, a factor favoring a good outcome. As the depression receded, the number of infertility patients was high. Careful study disclosed a history of induced abortion in many. Among these persons, the feeling of guilt was great, and they were difficult to handle. Fortunately in most cases the blocked tubes opened up 6 to 8 years post abortion, and pregnancies ensued to the point where the problem was one of the opposite sort.

As chairman of the abortion committee from the time the California abortion law was changed to the present time, I have been forced to learn about a whole group of persons whose values differ from mine in almost all respects. These values do not stem from tradition but seem to represent those in the nonthinkers who dominate the news media. Samples of this thinking are: "If you feel like doing something, do it. Don't take a chance on injuring your psyche by any sexual repression. If anyone warns you of dangers in your course of action, ignore him because he represents the "straight" generation. Don't use birth control pills, they're dangerous. Do have an abortion, it's simple, quick, and safe." I could go on with samples of cliches promoted by news media—unfortunately supported by enthusiasts in our profession who think any means should be used to promote their goals. Persons with these attitudes by and large form the group requesting abortions at our hospital. Now, the question arises, should we go along with these misconceptions so that the patient will regard the abortion as an exciting episode in her young life and become an authoritative dispenser of misinformation to her friends.

The complete lack of correct information appears to me to be the biggest problem to be solved relative to abortions. This we attempt to correct among our abortion applicants. Each case is considered individually. Trained social workers spend much time trying to work out problems bearing on the patient's decision. All community resources are brought to her attention. Pressure from the husband, boy friend, or parent is determined and discussed, and, in some instances with extensive discussion, other solutions than abortion are selected. The true facts with regard to abortion dangers and sequelae are presented, so that a truly knowledgeable decision can be made. After abortion, we have "rap" sessions where an effort is made to present to the patient the effect of life style on health, both mental and physical.

Without scientific knowledge to tell us the real end result of abortions, we reason the extensive individual effort will help to diminish the adverse results. The current efforts to streamline the process and make only formal compliance with legal requirements brings me to the observation made by my social worker, that ultimate efficiency will have as its result the barren goal of nothingness.

Dr. Eugene C. Sandberg, Palo Alto, California. It is interesting to note the similarity in figures emanating from different areas. The recurrence rate of undesired pregnancies in Dr. Margolis' series was ten per cent. Two years ago, Dr. Von der Ahe[1] mentioned in a report to this Society that the recurrence rate for illegitimate (and presumably undesired) pregnancies was nine per cent among the patients at 4 Los Angeles facilities for unwed pregnant women. At Stanford University Hospital during the past three years, we have also noticed that five to ten per cent of patients requesting therapeutic abortions have had prior undesired pregnancies.

Similarity in figures is also noticeable regarding subsequent utilization of contraception. Two years ago Tyler and associates[2] studied a group of women who had been admitted to Grady Memorial Hospital in Atlanta with or for an induced abortion. Upon dismissal, only seventy-five per cent accepted contraception. In Dr. Margolis' group, the figure was essentially the same. This seems to be a very low rate of acceptance of contraception for a group of women who have just procured an abortion.

Last, I think it would be foolhardy for anyone to believe that pregnancy will be prevented on a long-term basis, even in the group accepting contraception. It is well known that the two-year dropout rate is approximately fifty per cent for

essentially each of the contraceptive methods. Additionally, in Tyler's study, twenty-two per cent of the patients admitted with or for an induced abortion had previously attended the Grady Memorial Hospital Family Planning Clinic. Obviously, something didn't take. And their experience is not unique.

REFERENCES

1. Von der Ahe, C. D.: AMER. J. OBSTET. GYNEC. **104:** 279, 1969.
2. Tyler, C. W., Asher, J. D., and Freeman, M. G.: Induced Abortion and Family Planning, Presented at the Workshop on "Abortion, Obtained and Denied: Approaches to Outcomes," Bethesda, December 15, 1969, National Institute of Child Health and Human Development and National Institute of Mental Health. In press.

DR. J. OPPIE MCCALL, Portland, Oregon. Opponents and proponents of therapeutic abortion seem to take an exquisite delight out of presentations such as Dr. Margolis has given us. We seem to take delight on whichever side of the fence we are on as to some prospective analysis of the individual after the fact. Did she think it was a good idea? We have here, of course, an extremely small number of patients but even with a large number of patients we have an extremely varied group to try to analyze, anywhere from the 12 year old to the 45 year old, married and unmarried, etc. I find it difficult to even achieve any semblance of order out of trying to see how this patient regarded her abortion after it was done. However, let me fall into the same trap of wanting to compare how she feels before and after and ask Dr. Margolis a question which all these studies so far have failed to bring out. That is, regardless of age, marital status, etc., have the psychiatrist and the psychologist interpreted what the effect was of the early-trimester abortion as opposed to the mid-trimester abortion. My own observation is that I fear the girl with a second-trimester abortion is going to have a much more violent reaction to her abortion.

DR. MARGOLIS (Closing). I appreciate Dr. McDermott's observations based on his long practice of our specialty. Some of our abortion patients have patterns of sexual behavior which some might consider promiscuous; however, our incidence of positive preabortion gonorrhea cultures is one per cent whereas it is 3 to 4 per cent in our antenatal group.

With regard to Dr. McCall's observation, I agree that a second-trimester abortion is technically significantly different from first-trimester abortion. I think also that a candidate for abortion in the second trimester is a different patient than a candidate for abortion in the first trimester. Knowledge of abortion may not have been easily available to her, or more important she might have a marked degree of ambivalence that would aggravate any reaction to abortion.

VIEWS AND REVIEWS

PSYCHOLOGIC AND EMOTIONAL CONSEQUENCES OF ELECTIVE ABORTION

A Review

GEORGE S. WALTER, MD, MPH, FACOG

Should we consider abortion as temerity or therapy? Tradition impugns to the aborted woman a burden of guilt and social stigma. However, scrutiny of available literature suggests that there is really no documentation for significant psychiatric sequelae. The review suggests certain inadequacies of reported studies and underscores the need for carefully controlled, long-term, prospective observation of the woman seeking abortion, and of her family.

Unto the woman He said:
I will greatly multiply thy sorrow and thy conception;
In sorrow thou shalt bring forth children,
And thy desire shall be to thy husband,
And he shall rule over thee.

Genesis 3:16

THE DAUGHTERS OF EVE, long laboring under the burden of this terrible curse, are beginning to stir. Who, but they, can rightly divine the moment when their full creative powers should bloom? A voice is heard!



But, it was not always so. The ancient Assyrians decreed that she be impaled upon a stake and not dignified by burial should she exercise her own judgment. The fanfare that was Greece and Rome winked at, yea welcomed, both abortion and infanticide, and yet allowed the ascetic Pythagoreans to, once again, deprive each woman of her birthright. The debate has continued through the centuries, with the cudgel of church and civil law on the one side, and necessity on the other,[38,121,128] while in between, male philosophers tendentiously argue at what metaphysical point of time life begins after the chance collision of an aggressive motile cell with the wall of one that is less so.[4,82]

But woman has been adamant in her self-determination, and by whatever means fell to her knowledge or power, has attempted to control her fertility. The vacillating pendulum of public practice has swung toward a more liberal approach to induced abortion in recent years, till we have more abortions than births in Hungary,[87,102] and 1 out of every 8 Japanese doctors may be an abortionist.[117] And yet, we hear that in certain groups in the United States, 94% of

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The illustration at the top of the page is "Two Doctors in Discussion," from *Treatise Against All Pestilence and Tainted Air* by Alonso Espina, published in 1518 in Valladoled, Spain (The Bettmann Archive).

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pregnancies are unwanted![46] Confusion is no more rampant anywhere than in the professional arena, where we hear such cries as, "There are no nonmedical indications for abortion!" and "Teach chastity!"[40] The New Jersey Supreme Court has ruled that, "The unborn child would almost certainly choose life with defects as against no life at all."[33] Even such a prominent and usually progressive authority as Mary Calderone clouds the issue by saying, "Aside from the fact that abortion is the taking of a life, I am also mindful of what was brought out by our psychiatrists—that in almost every case, abortion, whether legal or illegal, is a traumatic experience that may have severe consequences later on."[18]

But, is this necessarily so? The purpose of this discussion will be to examine the woman who is faced with a pregnancy, to see upon what she bases her reaction to it, to consider with her the possible alternatives, and then to see what psychoemotional phenomena have been demonstrated by experience with women who have exercised their right not to bear a child.

A WOMAN LOOKS AT MOTHERHOOD

A woman will function appropriately and effectively as a mother if:

She achieves, besides language mastery, a level of abstract thought sufficient to see herself apart from others;

She esteems this concept of herself and finds it reliable;

Her actual self usually approximates this well-regarded image of herself;

She perceives the struggle out of which her identity evolved; and

She genuinely wants to be a mother.[109] She is expected to go through the progression of accepting her pregnancy (after an 85% initial rejection in primagravidas), developing an affiliative response to the fetus, and then assigning a reality-based identity to the newborn.[23] Fortunate indeed, are the majority of women who blissfully accomplish this metamorphosis from woman to mother.

If she is significantly maladapted in any one of these areas, then she may be one of the 3 to 13 women, per 1000 live births, who develops a significant puerperal psychologic illness.[13,30,68,88,160] The risk to her of recurrent episodes may increase tremendously with subsequent pregnancies.[72-74,116,134,161] So powerful is this emotional condition that illness has even been found in mothers after the adoption of children.[103] Indeed, her progression to emotional motherhood may be arrested, and the pregnancy will end. It has been postulated that the psyche might play a role in spontaneous abortion,[64,69] and most certainly does in habitual abortion; patients forced into motherhood and femininity by a successful Shirodkar procedure have had acute psychiatric disturbances.[152] This, then, is the powerful and overwhelming set of forces, some conscious, many others unconscious, focusing on the woman who contemplates bearing a child.

THE ALTERNATIVES TO CHILDBEARING

A woman may go ahead and bear her child, either adjusting reasonably well in the process, or rejecting the infant, although more will be said later about the child.[5,65]

She may threaten to procure, or even attempt, an illegal abortion,[47,65,100] particularly if she has been abandoned by her partner, and has hysterical traits.[4] She may actually obtain an illegal abortion, with its inherent dangers.[19,52,80,121] Interestingly enough, relaxation of abortion laws has not always led to a reduction of illegal abortions as was anticipated.[26,71,156]

She may threaten suicide, and in spite of suggestions to the contrary,[4,41-43,65,100,134] pregnant women do commit suicide, both before[16,21,123,158] and after termination of pregnancy.[145-148]

Whatever the patient's motivations or make-up, threats, whether toward abortion

or suicide, should be considered seriously and interpreted as signs of mental insufficiency and an inability to cope. This woman's behavior becomes an unpredictable entity.[4,158] Extensive studies of women who develop puerperal depression show that their personality make-up is such that their strong "mother-compliance" makes them very good patients and hard to recognize as women with great potential for acting-out behavior, either against themselves or the child.[36]

A woman's last alternative, available today only in certain privileged geographic and social circumstances, would be to seek a legal abortion. Let us digress slightly at this point to develop a train of logic which will set the stage for a consideration of the emotional sequelae of legal abortion.

We are told that neurotic women tend to have more pregnancies, abortions (all types), stillbirths, neonatal deaths, and psychiatric illness in their children.[96] We also know that there is a high degree of correlation between the prepregnancy state of mental health and the likelihood of puerperal illness.[4,35–36,41–43,70,94–95,100,113–115,130–137,156,158] Women with an earlier spontaneous abortion show significantly more psychiatric symptoms than others during subsequent pregnancies,[70] and some women have a "postabortion hangover" lasting until the projected term of the aborted pregnancy.[113] Mental illnesses associated with reproductive function account for 2–8% of all female psychiatric admissions,[30,88,160] with significant numbers of deaths,[7] and full recovery in only around 85%.[134]

If one of every five American pregnancies ends in abortion for some reason,[87] and if the incidence of mental insufficiency is higher after legal abortions,[67] and if some cognitive dissonance must be necessary to allow a woman to contemplate willful abortion, would it not be reasonable to expect a significant amount of mental illness after induced abortion?

EXPERIENCES WITH INDUCED ABORTION

There is a growing body of literature, much of it from northwestern Europe, and more recently from investigators in England and America, which discusses the psychiatric sequelae of induced abortion for nonmedical indications.[4,14,21,28,41–43,49,51,56,67,75,77,84,86–87,94–95,100,102,108,110,113–114,128,130–139,156,158] It is beyond the scope of this particular discussion to repeat the details of individual studies.

While there is some variation in their numbers and the quality of sampling and controls, if one removes the overlay of emotional, sentimental, and technical pejoratives, there is an amazingly consistent finding: legal abortion can be performed without fear of severe psychic harm to the woman. The reaction to abortion is determined almost entirely by a woman's previous psychologic set. Her feelings may fall into one of the following categories:

Guilt

Reported incidences varied from none at all to as high as 30%, with none severe. A critical factor in mild, immediate guilt is the actual physical setup of the clinical situation and the attitude of people caring for the patient. As time passed after the abortion, the degree of guilt decreased, until by one year, there was almost no guilt. What little did remain was frequently due to failure of the woman's manipulative effort, and was disguised as self-anger at the inability to structure a relationship or situation. True depression was rare, and suicide was almost absent from the data. The phenomenon of the so-called "atonement pregnancy," to make up for the one aborted, was noted in some studies, but has not been sufficiently investigated. While there was some concern about manifestations of delayed guilt, with possible involutional depression, none of the studies has progressed long enough to evaluate this yet.

Impaired Development of Adult Stages of Personality

This was found only if the woman proved sterile following the abortion, and this incidence was not greater than for normal pregnancy.[145,153,156] If she had a previous personality defect or frank illness, it might actually improve or remain essentially unchanged.

Disturbance of Relationship with the Opposite Sex

A woman might project her own childish or neurotic emotions upon her spouse and appease her own guilt by blaming it on him. This was particularly true if she had been pressured into the abortion by the man. The Kinsey group [49] went beyond mere figures showing patient satisfaction to evaluate a woman's subsequent performance in three areas. They found that 90% of postabortal unmarried women resumed premarital coitus, suggesting little psychic damage. Premarital abortion did not affect adversely the sexual adjustment in marriage as measured by the rate of orgasm during the first year of marital intercourse. And the incidence of marital break-up was actually lower in women who had had a premarital induced abortion. While one might argue with their criteria for measuring ill-effect, it does appear that their subjects' function was not interferred with.

When all the data are considered, we can probably say that legal abortion leaves its mark, just as does every other important event in a person's life. It is an unnatural way of solving conflict involved in an unwanted pregnancy. Women who are psychically vulnerable risk a deterioration in their condition through an unwelcome pregnancy and the extra load this involves, whatever course is adopted. Those who are mentally stable manage the pregnancy better. Those who come to therapeutic abortion are already highly selected in terms of their psychopathology. We must remember, therefore, in considering the rare unfavorable outcome that the pregnancy was a symptom of, rather than the cause of, the emotional disturbance, and that abortion was only a method of treating the symptom. Abortion may have no effect, or it may actually stabilize the underlying process.

Further Considerations of Effects of Abortion

We must think of any woman seeking abortion, even an unmarried one, as occupying a place in a social unit of interrelationships. In considering this unit, the most immediately apparent member is the sexual partner of the woman. A search of the literature reveals that there is really very little written about this important element of her psychologic field. Studies of women with puerperal emotional difficulties suggest that their husbands are frequently repeated images of their own rather weak and colorless fathers, and that the women feel victimized by and martyred to these ineffective men, whom they dominate. There is frequently a basic and covert sexual and procreative conflict which is unresolved as well. It is also known that women seeking abortion may do so at the insistence of partners whose neurotic behavior is being acted out upon their wives. The meaning of these relationships as well as of the induced abortion itself to the male is not clear.

Ekblad[41] reports that among the husbands of 479 women aborted upon psychiatric indications, 32% were neurotic, 14% more were alcoholic or criminal or both and 10% had somatic diseases. Hook reported similar patterns in 20% of partners of women who were refused abortion and 46% of partners of those granted abortion, suggesting once again that the request for abortion may have arisen from a mutual psychoemotional illness. The Kinsey group studies[49] report that following the abortion itself, only 4.2% of the male partners had

psychiatric consequences attributable to the abortion. This scanty data serves only to underline the importance of the man and the absence of any real body of information about his role.

Again, observing the woman as part of a biologic unit, we must ask about the effect of abortion upon children in that unit. Women seeking abortion on psychiatric grounds have been shown to have an immature emotional involvement with previous children.[109] Studies of puerperal illnesses suggest that when a mother has difficulty, it is not only a sick patient, but also a sick relationship between mother and child.[93] We also know that women with previous disturbances are the most likely to have repetitive episodes of disturbance when faced with pregnancy again, and that this disturbance can either lead a woman to request abortion or result in infanticide as often as once or twice in 500 births.[7,116] If abortion is selected as a solution to the immediate problem of an unwanted pregnancy, older children in the same family may misinterpret the act as a great threat and require psychiatric treatment.[100] From observing a group of 87 children whose mothers had aborted (type not specified), Cain reported two types of reactions: an immediate type, characterized by anxiety attacks, nightmares, increased aggressiveness, stuttering, running away, death phobias, increased separation anxiety, sudden outbursts of fear or hatred of the mother, and even suicide attempts; and a late type ranging from isolated fantasies to pervading, crucial, and disabling illness. He feels that the children's reactions are not predictable, but will be influenced by the degree of their knowledge of the abortion and their parent's attitude toward it and toward them. A very revealing retrospective study by Forssman and Thuwe followed 134 children born to 128 women who were refused abortion. Only 120 survived to 21 years. Seven and one-half percent were abandoned. They compared them to a self-selected control group of wanted children, and found that the "failed abortion" children had more family instability, more antisocial and criminal behavior, more drunken conduct, more military exemptions, less education, and needed more public assistance and psychiatric care. More of the girls in the unwanted group married early and had children early. Hook found in children under 12, born to mothers after abortion was refused them, an incidence of 22% disorders of behavior in the first 4 years of school, compared to 20% in the control group. There has not been adequate study of children, but we can conclude that the very fact that a woman applies for a legal abortion means that the prospective child risks having to surmount greater social and mental handicaps than his peers, even when the grounds for the application are so slight that it is refused. Legislation on therapeutic termination of pregnancy must consider the social risk to which the expected child will be exposed.

CRITICISM OF STUDIES REVIEWED

When the contributions of all authors are read and compared, some rather consistent defects in the body of knowledge and the methods used to obtain it are found.

Sampling methods are not uniform and not always good, so data may not be comparable. For example, psychiatric sequelae may be quite different in a cold, frightening, across-the-tracks type of abortion. Part of the guilt may actually be over money spent. A woman who has an abortion as the result of professional consultation shares the burden of decision. There is a high degree of self-selection in those seeking abortion. In the studies, there is no systematization of data gathering, and inadequate attempts are made to find those who do not return voluntarily. There may be a failure to standardize consideration of the patients by type of abortion—spontaneous, medically indicated, illegal or legal. The differentiation

and relationship between pre- and post-abortal psychopathology are not always clear. The meaning of the aborted pregnancy as well as that of subsequent pregnancies is not always investigated. Many of the studies mix patients who have concomitant sterilization with those were only aborted, and the majority of them have not followed their patients long enough to rule out late sequelae. Some of the evaluations of puerperal psychiatric illnesses do not include abortal histories. Only rarely does a study consider such factors as age, parity and spacing of children as influences on guilt formation. Probably one of the most serious errors is the almost universal projection of figures and results from Scandanavia into expectations from other countries. The difference in sociocultural concepts of abortion may make this a significant sociologic error.

PROFESSIONAL ATTITUDES TOWARD ABORTION

One cannot review this much material without being struck by the fact that one of the largest deterrents to a liberalized abortion policy, in spite of the public clamor, is the health profession itself.[10,21,53–4,59,61,97,116,128,138,156] Abortion is foreign to the attitudes fostered in physicians during their medical training; the gynecologist, the one to do the abortion, has a basic psychologic conflict. A whole generation of professional health workers refuses to let the myth die out that abortion will irreparably harm a woman and somehow place a stigma upon her. Physicians remain adamant. The male physician won't let the woman decide—reminiscent of the moralistic attitude about pain relief in childbirth before Queen Victoria demanded it for herself. The pregnant woman symbolizes proof of male potency, and if the male loosens his rule over women and grants them the right to dispose of that proof when *they* want to, the men then feel terribly threatened lest women can, at will, rob them of their potency and masculinity. This flaunting of traditional subservience may be one of the more powerful and less conscious determinants of our irrational opposition to granting women the right to decide matters in this crucial area of their lives. It may also function in the frequent professional insistence upon sterilization as a "package deal" with abortion. In this way the male physician can maintain control.[97,156]

CONCLUSIONS

Consideration of the emotional stresses of parturition would suggest that induced abortion could be a traumatic and damaging episode in a woman's life. Extensive review of the literature reveals that this has not been true. In fact, for the healthy woman with a happy marriage, abortion is most often truly therapeutic. There is still inadequate evaluation of the meaning of abortion to the woman's sexual partner and her other children. Various previous studies do not cast doubt upon our conclusion about the relative psychiatric safety of abortion, but they do point out the pressing need for baseline studies on the prevalence of psychologic disabilities resulting from other outcomes of pregnancy—the birth of a normal child, a premature child, a retarded or otherwise abnormal child; a neonatal death or late spontaneous abortion; and the consequences of unwanted parenthood for mother, child, family and community. Professional attitudes have been indicted as one of the major deterrents in keeping abortion from its rightful place as a useful tool in helping a couple thoughtfully and carefully plan their family.

Abraham Lincoln advised us well when he said, "The dogmas of the quiet past are inadequate to the stormy present. . . As our case is new, so must we think anew and act anew. . . We must disenthrall ourselves."

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REFERENCES

1. Aarons A: Therapeutic Abortion and the Psychiatrist. Amer J Psychiat 124:745, 1967
2. Addison P: Abortion Act, 1967. Lancet 2: 503, 1968
3. Amark C: Indications For Abortion in States of Psychic Insufficiency. Acta Psychiat Scand 34: Suppl 136:221, 1959
4. Anderson EW: Psychiatric Indications For the Termination of Pregnancy, J Psychosom Res 10:127, 1966
5. Aren P: On Legal Abortion in Sweden. Acta Obstet Gynec Scand 37:Suppl 1, 1958
6. Aren P, Amark C: Prognosis Where Abortion Granted But Not Carried Out. Acta Psychiat Scand 36:203, 1961
7. Arentsen K: Postpartum Psychosis. Danish Med Bull 15:97, 1968
8. Astrachan J: Severe Psychologic Disorders of the Puerperium. Obstet Gynec 25:13, 1965
9. Benson R, Collins H: The Medicolegal Aspects of Psychogenic Abortion. Clin Obstet Gynec 4:265, 1961
10. Bernstein I: Psychiatric Indications for Therapeutic Abortion. Minn Med 50:51, 1967
11. Bolter S: The Psychiatrist's Role in Therapeutic Abortion: The Unwitting Accomplice. Amer J Psychiat 119:312, 1962
12. Boulas SH, Preucel RW, Moore JH: Therapeutic Abortion. Obstet Gynec 19:222, 1962
13. Bratfos O, Haug J: Puerperal Mental Disorders in Manic Depressive Females. Acta Psychiat Scand 42:285, 1966
14. Brekke B: Other Aspects of the Abortion Problem.[18]
15. British Medical Association Committee on Therapeutic Abortion: Indications For Termination of Pregnancy. Brit Med J 1:171, 1968
16. Burke MF: Suicide in pregnancy. Brit Med J 2:49, 1968
17. Cain A, Erickson ME, Fast I, et al: Children's disturbed reactions to their mother's miscarriage. Psychosom Med 26:58, 1964
18. Abortion in the United States. Edited by MS Calderone. New York, Harper & Row, 1968
19. Calderone MS: Illegal abortion as a public health problem. Amer J Public Health 50: 948, 1960
20. Cheney C: Indications for therapeutic abortion. JAMA 103:1914, 1934
21. Clark M, Forstner I, Pond DA, et al: Sequels of unwanted pregnancy. Lancet 2:501, 1968
22. Cogan N: A medical social worker looks at the new abortion law. Brit J Med 2:235, 1968
23. Cohen R: Some maladaptive syndromes of pregnancy and the puerperium. Obstet Gynec 27:562, 1966
24. Cohen S: Abortion for the emotionally disturbed? J Med Ass Georgia 57:489, 1968
25. Corcoran C: Abortion—A catholic view. Illinois Med J 135:300, 1969
26. Cosgrove SA: Lack of Relation Between Therapeutic and Criminal Abortion. Quart Rev Surg Obstet Gynec 16:223, 1959
27. Council of the Royal College of Obstetricians and Gynecologists: Legalized Abortion. Brit Med J 5491:850, 1966
28. Crowley R, Laidlaw R: Psychiatric opinion regarding abortion: Preliminary report of a survey. Amer J Psychiat 124:559, 1967
29. Curran D: Psychiatric indications for the termination of pregnancy. New Zeal Med J 60:467, 1961
30. Daniels R, Lessow H: Severe postpartum reactions. Psychosomatics 5:21, 1964
31. Destounis N: Postpartum psychiatric syndromes. Delaware Med J 38:16, 1966
32. Deutsch H: The Psychology of Women, Motherhood, Vol 2, New York, Grune and Stratton, 1945
33. de Veber LL: Antenatal euthanasia. New Eng J Med 280:1248, 1969
34. Diggory PLC: Some experiences of therapeutic abortion. Lancet 1:873, 1969
35. Douglas G: Some emotional disorders of the puerperium. J Psychosom Res 12:101, 1968
36. Douglas G: Puerperal depression and excessive compliance with the mother. Brit J Med Psychol 36:271, 1963
37. Dunn HP: Therapeutic Abortion in New Zealand. New Zeal Med J 68:253, 1968
38. Eastman N: Induced abortion and contraception. Obstet Gynec Survey 22:3, 1967
39. Ebaugh F, Heuser KD: Psychiatric aspects of therapeutic abortion. Postgrad Med 2: 325, 1947
40. Editorial. New Eng J Med 280:1240, 1969
41. Ekblad M: Induced abortion on psychiatric grounds: A follow-up study of 479 women. Acta Psychiat Scand 31: Suppl 99:1, 1955
42. Ekblad M: Proceedings, International Planned Parenthood Conference, Stockholm, 1953
43. Ekblad M: Psychiatric follow-up study of women after legal abortion. Acta Psychiat Scand (Suppl) 80:162, 1953
44. Enoch MD: Psychiatric sequelae to the termination of pregnancy. Brit Med J 1:563, 1967
45. Field M: The Re-legalization of Abortion in Soviet Russia. New Eng J Med 255:421, 1956
46. Flowers CE: Address at Navajo Obstetrics and Gynecology Seminar, Gallup, New Mexico, 1968
47. Forssman H, Thuwe I: One hundred twenty children born after application for therapeutic abortion refused. Acta Psychiat Scand 42:71, 1966

48. Freundt L: Surveys in induced and spontaneous abortions in the Copenhagen area. Acta Psychiat Scand 40:Suppl 180:235, 1964
49. Gebhard PH, Pomeroy WB, Martin CE et al: Pregnancy, Birth, And Abortion. New York, Harper & Row, 1958
50. George BJ: Current abortion laws. Illinois Med J 131:696, 1967
51. Gillis A: Follow-up after abortion. Brit Med J 1:506, 1969
52. Gold E, Erhardt CL, Jacobziner H, et al: Therapeutic abortion in New York: Twenty year review, Amer J Public Health 55:964, 1965
53. Guttmacher A: "Therapeutic Abortion: One Physician's Viewpoint," Quart Rev Surg Obstet Gynec 16:235, 1959
54. Guttmacher A: "The Shrinking Non-Psychiatric Indications for Therapeutic Abortion.[122]
55. Hammond H: Therapeutic abortion. Amer J Obstet Gynec 89:349, 1964
56. Harrison CP: On the futility of legalizing abortion. Canad Med Ass J 95:360, 1966
57. Harrison C: Teenage pregnancy—Is abortion the answer? Pediat Clin N Amer 16: 363, 1969
58. Hartman R, et al: A symposium: Medical implications of the current abortion law in Illinois. Illinois Med J 131:666, 1967
59. Hauschild T: The role of the psychiatrist in therapeutic abortion and sterilization. Med Bull US Army Europe 20:322, 1963
60. Hayman A: Some aspects of regression in non-psychotic puerperal breakdown. Brit J Med Psychol 35:135, 1962
61. Heller A, Whittington H: The Colorado story: Denver General Hospital experience with the change in the law on therapeutic abortion. Amer J Psychiat 125:809, 1968
62. Helpern M: The problem of criminal abortion. Quart Rev Surg Obstet Gynec 16:231, 1959
63. Hemphill RE: Incidence and nature of puerperal psychiatric illness. Brit Med J 2: 1232, 1952
64. Henker F: Abortion and sterilization from psychiatric and medico-legal viewpoints. J Arkansas Med Soc 57:368, 1961
65. Hook K: Refused abortion. Acta Psychiat Scand 39:Suppl 168, 1963
66. Ingram J, Treloar HS, Thomas GP, et al: Interruption of pregnancy for psychiatric indications—A suggested method of control. Obstet Gynec 29:251, 1967
67. Jansson B: Mental disorders after abortion. Acta Psychiat Scand 41:87, 1965
68. Jansson B: Psychic insufficiencies associated with childbearing. Acta Psychiat Scand 39: Suppl 172, 1963
69. Javert C: Psychosomatic aspects of habitual abortion. Med Times 90:115, 1962
70. Jacobson L, Kaij L, Nilsson A: Post-partum mental disorders in an unselected sample: Frequency of symptoms and predisposing factors. Brit Med J 1:1640, 1965
71. Jensen M: quoted in Foreign Letters. JAMA 157:1578, 1955
72. Kaij L, Jacobson L, Nilsson A: Postpartum mental disorders in an unselected sample: The influence of parity. J Psychosom Res 10:317, 1967
73. Kaij L, Jacobson L, Nilsson A: Postpartum mental disorders in an unselected sample: The psychiatric history. J Psychosom Res 10:327, 1967
74. Kaij L, et al: Postpartum mental disorder in an unselected sample: The importance of the unplanned pregnancy. J Psychosom Res 10:341, 1967
75. Kaij L, Malmquist A, Nilsson A: Psychiatric aspects of spontaneous abortion: II. The importance of bereavement, attachment, and neurosis in early life. J Psychosom Res 13: 53, 1969
76. Kane F, Ewing J: Therapeutic abortion—Quo vadimus? Psychosomatics 9:202, 1968
77. Kay DWK, Shapira K: Psychiatric sequelae of termination of pregnancy. Brit Med J 1:5535:299, 1967
78. Kear-Colwell JJ: Neuroticism in the early puerperium. Brit J Psychiat 111:1189, 1965
79. Kenin L, Blass N: Mental illness associated with the postpartum state. Clin Obstet Gynec 5:716, 1962
80. Uhrus K: Some aspects of the Swedish law governing termination of pregnancy. Lancet 2:1292, 1964
81. Kestenberg J: Outside and inside, male and female. J Amer Psychoanal Ass 16:457, 1968
82. Knutson A: When does a human life begin? Viewpoints of public health professionals. Amer J Public Health 57:2163, 1967
83. Koeniger P: The physician and abortion law. Alaska Med 10:119, 1968
84. Kolstad P: Therapeutic abortion. Acta Obstet Gynec Scand 36: Suppl 6, 1957
85. Koya Y: A study of induced abortion in Japan and its significance. Milbank Mem Fund Quart 32:282, 1954
86. Kretzchmar RM, Norris AS: Psychiatric implications of therapeutic abortion. Amer J Obstet Gynec 198:368, 1967
87. Kummer J: Post-abortion psychiatric illness—A myth? Amer J Psychiat 119:980, 1963
88. Kummer J: Psychiatric contraindications to pregnancy. Calif Med 79:31, 1953
89. Lader L: Abortion. Indianapolis, Bobbs-Merrill Co, Inc, 1966
90. Laidlaw R: Other aspects of the abortion problem.[18]
91. Leng GA: British abortion law amendment. Singapore Med J 9:59, 1968

92. Lidz T: Other aspects of the abortion problem.[18]
93. Lomas P: Observations on the psychotherapy of puerperal breakdown. Brit J Med Psychol 34:245, 1961
94. Malmfors K: Status of women after legal abortion. Svensk Lakartidn 48:2445, 1951
95. Malmquist A, Kais L, Nilsson A: Psychiatric aspects of spontaneous abortion: I. A matched control study of women with living children. J Psychosom Res 13:45, 1969
96. Mandelbrote BM, Monro M: Neurotic illness as a factor in reproduction. Acta Psychiat Scand 40:419, 1964
97. Mandy AJ: Reflections of a gynecologist.[122]
98. Mandy T, Scher E, Farkas R, et al: The psychic aspects of sterility and abortion. Southern Med J 44:1054, 1951
99. Mann E: Psychiatric investigation of habitual abortion. Obstet Gynec 7:589, 1956
100. McCoy D: The emotional reaction of women to therapeutic abortion and sterilization. J Obstet Gynaec Brit Comm 75:1054, 1968
101. McGraw R: Legal aspects of termination of pregnancy on psychiatric grounds. New York J Med 54:1605, 1956
102. Mehlan KH: Combatting illegal abortion in the socialist countries of Europe. World Med J 13:84, 1966
103. Melges F: Postpartum psychiatric syndromes. Psychosom Med 30:95, 1968
104. Meyerowitz S, Romano J: Who may not have an abortion? JAMA 209:260, 1969
105. Montagu MF: Introduction.[18]
106. Montgomery T, Lewis A, Hammersly M: Maternal deaths in California 1957–1962. Calif Med 100:412, 1964
107. Moore R: Psychiatric and legal aspects of therapeutic abortion and sterilization. New Zeal Med J 58:772, 1959
108. Muller C: The dangers of abortion. World Med J 13:78, 1966
109. Mumford RS: An interdisciplinary study of four wives who had induced abortions. Amer J Obstet Gynec 87:865, 1963
110. Niswander K, Patterson R: Psychologic reaction to therapeutic abortion. Obstet Gynec 29:702, 1967
111. Norris AS: The tired mother. J Iowa Med Soc 54:478, 1964
112. Nuckols F: Postpartum and postoperative psychiatric emergencies: Related syndromes. Alabama J Med Sci 2:264, 1965
113. Patt S, Rappaport RG, Barglow P: Follow-up of therapeutic abortion. Arch Gen Psychiat (Chicago) 20:408, 1969
114. Peck A: Therapeutic abortion: Patients, doctors, and society. Amer J Psychiat 125:797, 1968
115. Peck A, Marcus H: Psychiatric sequelae of therapeutic interruption of pregnancy. J Nerv Ment Dis 143:417, 1966
116. Pitt B: Atypical depression following childbirth. Brit J Psychiat 114:1325, 1968
117. Pommerenke WT: Abortion in Japan. Obstet Gynec Survey 10:145, 1955
118. Robb DF: The abortion act of 1967. Practitioner 201:694, 1968
119. Robinson D: Management of combined organic and emotional factors in a post partum psychosis. Minn Med 49:1897, 1966
120. Roger TF: Attitude toward abortion. Amer J Psychiat 125:804, 1968
121. Abortion in America. Edited by H Rosen. Beacon Press, Boston, 1967
122. Therapeutic Abortion. Edited by H Rosen. Julian Press, New York, 1954
123. Rosenberg A, Silver E: Suicide, psychiatrists and therapeutic abortion. Calif Med 102: 407, 1965
124. Royal Medico-Psychological Association, Memorandum on Therapeutic Abortion, Brit J Psychiat 112:1071, 1966
125. Russell KP: Therapeutic abortions in California in 1950. Western J Surg 60:497, 1952
126. Sandosham AA: Legal abortion. Med J Malaya 22:167, 1968
127. Sandosham AA: Our abortion laws. Med J Malaya 22:165, 1968
128. Schwarz RA: Psychiatry and the abortion laws: An overview. Compr Psychiat 9:99, 1968
129. Senay E: Post partum depression: A case review, diagnostic, treatment, and sociomedical aspects. Conn Med 30:645, 1966
130. Shainess N: Abortion: Social, psychiatric, and psychoanalytic perspectives. New York J Med 68:3070, 1968
131. Sim M: Abortion and the psychiatrist. Brit Med J 5358:680, 1963
132. Idem: Abortion and the psychiatrist. Brit Med J 5350:145, 1963
133. Idem: A guide to psychiatry. London, Livingstone, 1968
134. Idem: Psychiatric disorders of pregnancy. J Psychosom Res 12:95, 1968
135. Simon A: Psychiatric indications for therapeutic abortion and sterilization. Clin Obstet Gynec 7:67, 1964
136. Simon N, Senturia A, Rothman D: Psychiatric Illness Following Therapeautic Abortion. Amer J Psychiat 124:59, 1967
137. Simon N, Senturia A: Psychiatric sequelae of abortion. Arch Gen Psychiat (Chicago) 15:378, 1966
138. Sloane RB: The unwanted pregnancy. New Eng J Med 280:1206, 1969
139. Sorrel WE: Abortion: Its psychodynamic effects. Psychosomatics 8:146, 1967
140. Stephenson HA: Therapeutic abortion. Obstet Gynec 4:578, 1954
141. Taylor ES, Droegemueller W, Drose V: The first year of experience in Colorado with the

new abortion law. Amer J Obstet Gynec 103:694, 1969
142. Teeter R: Psychiatric indications for abortion. Minn Med 50:49, 1967
143: Thurstone P: Therapeutic abortion. JAMA 209:229, 1969
144. Tietze C, Lewit S: Abortion, Sci Amer 220: 21, 1969
145. Tietze C: Induced abortion and sterilization as methods of fertility control. J Chronic Dis 18:1161, 1965
146. Tietze C: Legal abortion in Scandinavia. Quart Rev Surg Obstet Gynec 16:227, 1959
147. Tietze C: Therapeutic abortions in New York City, 1943–1947. Amer J Obstet Gynec 60:146, 1950
148. Idem: Therapeutic abortion in the United States. Amer J Obstet Gynec 101:784, 1968
149. Tod EDM: Postpartum depression. Lancet 2:1264, 1964
150. Tredgold RF: Psychiatric indications for the termination of pregnancy. Lancet 2:1251, 1964
151. Turner GP, Jr: Postpartum and postoperative psychiatric emergencies: A description of the syndromes. Alabama J Med Sci 2: 251, 1965
152. Vanden Bergh RL, Taylor ES, Drose V: Emotional illness in habitual aborters following suturing of the incompetent cervical os. Psychosom Med 28:257, 1966
153. Warner M: Successful pregnancies after spontaneous and induced abortions. Western J Surg 64:504, 1956
154. Watson T: Why therapeutic abortion? Minn Med 50:55, 1967
155. Westoff C, Moore EC, Ryden NB: The structure of attitudes toward abortion. Milbank Mem Fund Quart 47:11, 1969
156. White R: Induced abortions: A survey of their psychiatric implications, complications, and indications. Texas Rep Biol Med 24: 531, 1966
157. Wiener A, Steinhilber R: The postpartum psychoses. J Int Coll Surg 36:490, 1961
158. Wilson DC: Psychiatric implications in abortions. Virginia Med Monthly 79:448, 1952
159. Winokur G, Ruangtrakool S: Postpartum impact on patients with independently diagnosed affective disorders. JAMA 197:242, 1966
160. Wolff T, Caldwell J: Psychiatric aspects of therapeutic abortion. Florida Med Ass J 52:95, 1965
161. Yalom I, Lunde DT, Moos RH, et al: Postpartum blues syndrome. Arch Gen Psychiat 18:16, 1968

THERAPEUTIC ABORTION

Definitions. Therapeutic abortion is the termination of pregnancy before the period of fetal viability for the purpose of saving the life of the mother or safeguarding her health. Because concepts are changing rapidly, the definition of therapeutic abortion lacks precision. The word "health" in particular is variously interpreted. In its broadest sense, as defined by the World Health Organization, it applies not only to physical health but also to mental health and social well-being. Therapeutic abortion, unlike any other surgical operation, is governed by statute or common law in all states, but the wording of the regulations differs widely. In the strictest sense the law in most states does not permit the procedure for reasons such as illegitimacy, poverty, or rape, or on the basis that the infant is likely to be gravely malformed. Despite its apparent simplicity the law remains vague because the definitions of "life," "save," and "preserve" are subject to widely varying interpretation. For example, one English high court has acquitted a physician for performing therapeutic abortion in a case of rape of a young girl (*Rex* v. *Bourne*. For details see Harper). Abortions are commonly performed in cases of rubella, as a result of which the child may be malformed. In a time of rapidly changing laws, concepts, and mores, therapeutic abortion cannot be defined nor can the listing of its indications carry any degree of accuracy or permanence.

Legal Status. Contrary to popular belief today's stringent abortion laws are of fairly recent origin. Before quickening (the term applied to the first definite perception of fetal movement, which occurs between the sixteenth and twentieth weeks of gestation), abortion was either lawful or widely tolerated in both the United States and Great Britain until 1803. In that year, as part of a general overhaul of British criminal law, a basic criminal abortion law was enacted that made abortion before quickening illegal. Canon law, creating the dogma that in no circumstance is abortion justifiable, was established in 1869 by Pope Pius IX (Pilpel and Norwick).

The British law of 1803 became the model for similar laws in the United States, but it was not until 1821 that Connecticut enacted the nation's first abortion law. Throughout the nation abortion became illegal except to save the life of the mother. In a few states, the word "health" was added. Until very recently therapeutic abortion in most states was legally permissible only if it was necessary to save the *life* of the mother. Two states extended the exception to "to prevent serious or permanent bodily injury"; and in another two, the exception read "to preserve the life or health of the woman." If the "health of the woman" be construed to include her mental health, still in only two states was therapeutic abortion legally permissible on psychiatric indications or to prevent the birth of a malformed child (as in rubella), which might affect the mother's mental health. Since therapeutic abortion to save the *life* of the woman is rarely necessary, it follows that the great majority of such operations performed in this country went and still go beyond the letter of the law. Nevertheless, experience has shown that if a reputable physician, with the written approval of two other reputable physicians, carries out the operation openly in an accredited hospital, the propriety of the operation is rarely questioned by officers of the law. (For details of the legal status of therapeutic abortion in the United States, consult Harper). Many hospitals have set up abortion committees to decide the permissibility of abortion. Because the intent of these committees is to protect the reputation of the hospital, they have, in general, tended to be restrictive.

There is a growing body of both professional and lay opinion in favor of liberalization of the abortion laws. In 1943, the prestigious New York Academy of Medicine was among the first medical organizations to recognize the need for reform. Since that time the Academy has issued three statements on the subject; the last in 1969 favors repeal of existing abortion laws.

In 1959, the American Law Institute suggested a Model Penal Code governing abortion. This code would authorize therapeutic abortion when a licensed physician believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or that the child would be born with grave physical or mental defects, or that the pregnancy resulted from rape by force, or incest. Two physicians must certify in writing their belief in the justifying circumstance.

In 1967 the House of Delegates of the American Medical Association went on record as supporting reform of the abortion laws conforming to the general guidelines set forth in the Model Penal Code. In 1965 the American College of Obstetricians and Gynecologists recommended, in addition to the provision of the Model Penal Code, that social and total economic environment, actual or reasonably foreseeable, be considered as having a bearing on the health of the mother.

Between 1967 and 1969 eleven states amended their abortion laws by extending the indications for therapeutic termination of pregnancy. The new abortion act in Great Britain (1967) is among the most permissive of all recently enacted statutes. It contains two significant clauses in respect to the ascertainment of health of the mother:

1. "Account be taken of the pregnant woman's actual or reasonably foreseeable environment.
2. "Account be taken not only of the effect of pregnancy on the mother but on any existing children of her family."

If liberally construed, the current British abortion law is tantamount to virtually unrestricted abortion.

The report of Governor Rockefeller's special commission to review the New York State Abortion Law was published in March, 1968. The recommendations follow the Model Penal Code, but add two additional indications for abortion as follows:

1. "The pregnancy commenced while the female was unmarried and under 16 years of age, and is still unmarried.
2. "When the female already has four living children."

The principal arguments in favor of a more permissive abortion statute have been summarized by the Governor's special commission as follows:

1. "The deaths, sterility and harmed physical and mental health, resulting from the large number of illegal abortions each year could largely be prevented if such abortions were performed by competent physicians in proper hospital surroundings, within the framework of reasonable legislation.
2. "The wide disparity between the statutory law and actual practice encourages disrespect for the law and places upon the conscientious physician an intolerable conflict between his medical duty to his patients and his duty as a citizen to uphold the law.
3. "The present law places an unfair discrimination on the poor. Persons with money may obtain safe abortions either by traveling to other jurisdictions, by going to high-priced, competent though illegal abortionists, or by obtaining legal abortion here based on 'sophisticated' psychiatric indications."

The divergence between the literal interpretation of the law and current medical practice has led today's physician into an area of grave legal risk. There are indications that the courts may take action when reputable medical practice in accredited hospitals does not conform to strict interpretation of rigid abortion laws.

In 1969 there were two court decisions of major importance in this field. On September 5 the California Supreme Court in the case of *People* v. *Belous* declared the pre-1967 California abortion law unconstitutional on the following grounds:

1. The phrase "necessary to preserve life" is unconstitutionally vague;
2. "The fundamental rights of the woman to choose whether to bear children" is a right of privacy which the statute unconstitutionally abridges;
3. The statute violates the Fourteenth Amendment because of the "delegation of decision making power to a directly involved individual" (i.e., the doctor might be penalized for approving a request for abortion but not for denying a request).

In November, 1969, a decision in the United States District Court for the District of Columbia declared unconstitutional that part of the statute outlawing abortions other than those done "for the preservation of the mother's life or health." The reasoning was similar to, and in part relied upon, that in the *Belous* decision.

The New York law was recently challenged in the Federal Court for the Southern District of New York. The complaint in this case alleged that the abortion law is unconstitutional on grounds similar to those cited in the California case.

Minority reports accompanying many of these reports and resolutions are best summarized by the conclusion to The Minority Report of the Governor's Commission Appointed to Review New York State's Abortion Law, as follows: "Because we consider the proposals of the majority of our Committee to be violative of the fundamental rights of the human child *in utero* and detrimental to our traditional and still viable ideals of the sanctity of human life and the integrity of the family unit, we dissent."

The reform of abortion laws along the guidelines drawn by the American Law Institute has not worked well. Although the number of abortions has increased markedly, the poor still find it difficult to obtain abortions even in situations of obvious merit. Illegal abortions have probably not decreased. The laws are vague and in many instances capriciously interpreted (Monroe; Russell and Jackson; Droegemueller and co-workers; and Overstreet)

Although some states, notably Hawaii, Alaska, Washington, and New York have repealed their abortion laws, in most instances the solution to this complex problem may stem not from legislative reform of existing statutes but from action

of the courts on the constitutionality of abortion laws. (For full discussion of the constitutional questions, see Lucas.)

Indications. The indications for therapeutic abortion are discussed with the diseases that most commonly lead to the operation. A well-documented indication is heart disease in the wake of previous decompensation (p. 783). Another commonly accepted indication is advanced hypertensive vascular disease (p. 738). Still another is carcinoma of the cervix (p. 641).

Currently the two most frequently encountered indications for therapeutic abortion are psychiatric disease and potential abnormalities of the fetus. Among 4,675 therapeutic abortions performed in New York City between 1951 and 1962, inclusive, the major indication for the operation was a mental disorder (Gold and co-workers). Many, however, believe that interruption of pregnancy on psychiatric grounds is often a double-edged sword, which may aggravate rather than ameliorate psychotic tendencies. In the opinion of both Pearce and Martin, when the operation is carried out on mentally unstable women, 25 to 59 per cent are left with remorse and guilt. Even in the case of abortion for nonpsychiatric indications, Gebhard and associates found evidence of prolonged psychiatric trauma in 9 per cent of a sample of American women in whom the operation had been performed therapeutically or criminally. McCoy found that 27 percent of 62 women questioned at least one year after therapeutic abortion expressed varying degrees of regret. Seventy-three per cent of his patients were satisfied, and those for whom pregnancy was socially untenable rarely regretted the operation. Niswander and Patterson found that a similar percentage of their patients regretted the operation. Sim, an English psychiatrist, makes the sweeping statement: "There are no psychiatric grounds for termination of pregnancy." There is little information about the psychologic impact on the patient of refusal of her request for abortion. These women rarely commit suicide even though they may threaten to do so; however, among 249 Swedish women who were denied abortion, Hook found only 23 per cent who had accepted the situation and made a satisfactory adjustment.

Potential abnormality of the fetus as an indication for therapeutic abortion comes up most frequently in connection with maternal rubella. We believe that the operation is justified in selected cases (p. 808). As intrauterine diagnostic technics improve, the problem of serious fetal malformation will present more frequently. Valenti and colleagues have reported a therapeutic abortion performed on the basis of a firm diagnosis of Down's syndrome. Recently Schneck and colleagues have made an intrauterine diagnosis of Tay Sachs enzymatic disease. Other enzymatic disorders can be diagnosed with reasonable accuracy (Ch. 38, p. 1078).

It is impossible to predict what the future acceptable indications for therapeutic abortion will be. It is certain, however, that public opinion will not tolerate much longer the disregard of patients with unwanted pregnancies complicated by serious social problems. The new abortion policy of the American College of Obstetricians and Gynecologists succinctly states the matter as follows:

> Therapeutic abortion may be performed for the following established medical indications:
>
> 1. When continuation of the pregnancy may threaten the life of the woman or seriously impair her health. In determining whether or not there is such risk to health, account may be taken of the patient's total environment, actual or reasonably foreseeable.

2. When pregnancy has resulted from rape or incest: In this case the same medical criteria should be employed in the evaluation of the patient.
3. When continuation of the pregnancy is likely to result in the birth of a child with grave physical deformities or mental retardation.

Incidence. Tietze and Lewit estimate that about 8,000 therapeutic abortions per year were performed in hospitals in the United States from 1963 to 1965 (see also Rosen). This ratio of about 2 abortions per 1,000 live births contrasts with 79 per 1,000 live births in Sweden. In Hungary the number of abortions exceeds the number of live births. As the result of a sharp and continuing decline in traditional medical indications (heart disease, hypertension, pulmonary tuberculosis, and hyperemesis, for example), the number of operations performed on these grounds has fallen dramatically over the past two decades, with the result that interruption of pregnancy on physical indications is becoming rare.

Technic. Vaginal therapeutic abortion may be performed by the traditional dilatation and curettage or by the more recently introduced suction technic. The likelihood of uterine perforation, cervical laceration, hemorrhage, incomplete removal of the placenta, and infection increases sharply after the twelfth week, and perhaps somewhat earlier in primigravidas; for this reason neither dilatation and curettage nor suction curettage should be performed when the duration of pregnancy has exceeded that limit. If interruption of more advanced pregnancy is urgent, abdominal hysterotomy, hysterectomy, or intraamniotic injection of hypertonic saline are preferable.

There are other circumstances in which abdominal hysterotomy or hysterectomy is preferable to the vaginal operation. If, for example, sterilization is to be included in the procedure, combining hysterotomy with tubal ligation in a single operation or performing a hysterectomy is sometimes preferable to the two separate procedures. If the therapeutic abortion is done for medical or serious psychiatric indications, it is often carried out abdominally, because many of these indications for the operation are sound reasons for sterilization also. Still another advantage of abdominal hysterotomy is the greater likelihood of complete evacuation of the uterine contents, particularly if care is exercised in incising the uterine wall, so that the gestational sac may be delivered intact.

Light inhalation anesthesia with or without a muscle relaxant is usually satisfactory for the vaginal operation. The cervix is more easily dilatable if 1 per cent procaine or xylocaine is injected bilaterally into the paracervical tissues. Warming of the dilators is also helpful. To lessen the likelihood of uterine perforation an infusion of 10 units of oxytocin in 500 ml of saline or Ringer's lactate solution is sometimes given slowly during the operation. After the usual preparations for a vaginal operation, the cervix is grasped with a tenaculum and the depth of the uterine cavity is measured by a sound. Care is taken that no instrument be introduced into the uterus beyond that depth. The cervix is very gradually dilated with a series of Hegar dilators (Fig. 1). As shown in Figure 2, the fourth and fifth fingers of the hand introducing the Hegar dilators should rest on the patient's buttock as a further safeguard against uterine perforation. It is our opinion that a sharp curette is more efficacious and that its dangers are not greater than those of the dull instrument in the usual therapeutic abortion. Perforations of the uterus rarely occur on the downstroke of the curette but may occur when any instrument is introduced into the uterus; since the knife edge of a sharp curette is directed downward, it can have no bearing on this hazard. Any curette, however, is a

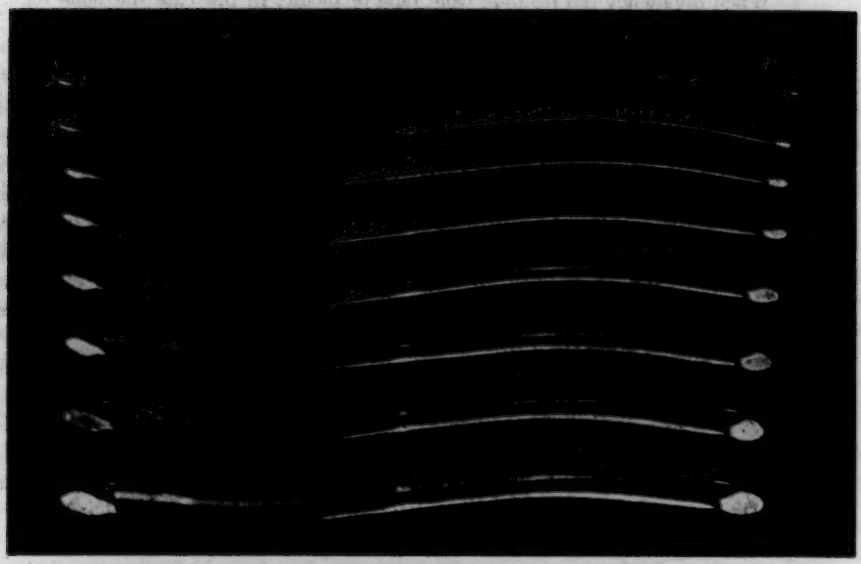


Fig. 1. Hegar graduated dilators.



Fig. 2. Dilatation of cervix with Hegar dilator. Note that the fourth and fifth fingers rest against the buttock. This maneuver is a most important safety measure because, if the cervix relaxes abruptly, these fingers prevent a sudden and uncontrolled thrust of the dilator, a common cause of perforation of the uterus.

dangerous instrument if injudicious force is applied to it. As shown in Figure 3 the necessary manipulations should be carried out with the thumb and forefingers only.

Suction curettage, introduced by Wu and Wu in China in 1958, has furnished

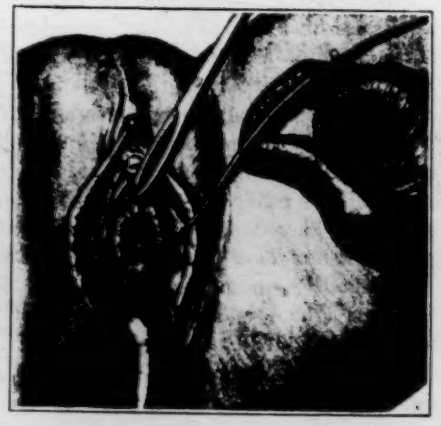


Fig. 3. Introduction of the curette. Note that the instrument is held merely with the thumb and forefinger; in the upward movement of the curette only the strength of these two fingers should be used. Moreover, just as soon as the curette has entered the cervical canal, the fourth and last fingers rest on the buttock as further protection against uterine perforation. Still another safeguard is the administration of 5 units of oxytocin 15 minutes before the operation and again as the patient is being draped.

a quick, nearly painless and almost completely safe method of performing therapeutic abortions before the twelfth week of gestation This technic is now the method of choice in the U.S.S.R. (Reid) and in other countries of eastern Europe. It is receiving increasing attention in Great Britain (Kerslake and Casey) and in the United States. The suction curettes are hollow tubes of different diameters, with a moderate-sized opening at or near the tip. A glass trap is interposed between the curette and a vacuum pump. Under paracervical block or light general anesthesia the cervix is dilated sufficiently to allow passage of the curette. Oxytocin is usually administered, and suction up to 760 mm Hg is obtained by covering the bypass at the base of the curette with the thumb. The curette is swept gently around the interior of the uterus until no further products of conception can be seen entering the trap. The entire procedure takes from two to three minutes. It is too soon to predict whether current enthusiasm for this method will be sustained. Perforation of the uterus is not unknown, however.

After the fourteenth week of pregnancy, when the fundus can be palpated through the abdominal wall, abortion may be brought about by the intraamniotic injection of hypertonic saline or 50 per cent glucose solution. The exact mechanism of action is still uncertain. Klopper has shown a rapid fall in estriol excretion after the injection of hypertonic saline. Pregnanediol remains at the same level, however, until the abortion is terminated. Such technics are not new, Boero having produced abortion with an intraamniotic injection of dilute formalin as early as 1935. In 1958, Brosset passed a needle through the abdominal wall into the uterine cavity, withdrew 50 ml of amniotic fluid, and injected an equivalent amount of 50 per cent dextrose in water. In his series, the interval between injection and abortion averaged 38 hours. Since then, articles by numerous authors (Jaffin and associates; Wood and colleagues; Weingold and co-workers; and Gochberg and Reid) have attested the efficacy of this method, using 50 to 200 ml of either 50 per cent dextrose or the even more effective 20 per cent saline. These technics may obviate the necessity for hysterotomy in therapeutic abortion. Although they are far safer than the original technic utilizing formalin, there is danger of infection, especially when dextrose solution is employed. Peel has reported a death from this

procedure, caused by the staphylococcus, and Briggs and MacDonald and colleagues have reported deaths caused by *Clostridium perfringens*.

Inadvertent introduction of hypertonic saline into the maternal circulation carries the likelihood of serious central nervous system and cardiopulmonary reactions. Cameron and Dayan have reported two new deaths as well as five others collected from the literature. All the patients had a high concentration of sodium in the blood and damage to the brain. Six patients showed extreme dehydration. Another reported complication following hypertonic saline is defective hemostasis caused by hypofibrinogenemia and related coagulation defects (Goldstein and also Quilligan). Between 1946 and 1950, more than 70 papers on this technic were published. There were 18 deaths between 1949 and 1952 alone (Wagatsuma). The method is no longer used in Japan. In contrast, both Goodlin and Schiffer report good results in moderately large series. Eastman comments on these studies as follows: "The intraamniotic injection of hypertonic saline for the induction of labor, if without substantial hazard, fills a real need in obstetrics; but only time will tell whether precautionary measures against hypernatremia will prevent such catastrophes as here reported."

In 22,179 cases, both gynecologic and obstetric, in which dilatation and curettage were performed for various reasons in two Baltimore hospitals, perforation of the uterus was recognized in 47, or once in about 500 operations, as reported by Radman and Korman. This figure agrees fairly well with that of Kushner and Dill, who report one known perforation in 700 operations. Although it is customary to regard the curette as the main offending instrument, Kushner and Dill point out that in their series of 21 perforations the curette caused less than one third. In the remainder a sponge stick, a sound, or dilators (both Hegar and Goodell) were the perforating instruments in about equal numbers.

The management of perforation of the uterus depends on the clinical events following the accident, particularly with regard to the extent of damage to other pelvic or abdominal viscera. Constant close observation of the patient for signs of peritoneal irritation or abdominal hemorrhage is therefore required. In the Baltimore series cited, abdominal exploration was deemed advisable in about one half the cases. In other series the comparable fraction has been somewhat smaller, averaging perhaps one third or less. In doubtful cases of perforation expectant treatment is the best course.

The morbidity and mortality rates from therapeutic abortion can be documented only from countries with permissive laws. In 23,666 therapeutic abortions performed in Denmark, the mortality rate was 0.7 per 1,000 operations, and serious but nonfatal sequelae ensued in 3.2 per cent (Berthelsen and Østergaard). These sequelae included 82 cases of perforation of the uterus and 122 cases of salpingitis, peritonitis, and septicemia. In addition, 113 cases of nonfatal but serious complications followed 5,320 abdominal hysterotomies, or 2.1 per cent.

The mortality rates appear to be correlated closely with the ease of obtaining abortion and the period in pregnancy when the operation is performed. Thus there is a mortality rate of about 4 per 100,000 abortions in the countries of eastern Europe and Japan, where abortion is not permitted after the third month of pregnancy and is entirely permissive. In contrast, the mortality rate is nearly 70 per 100,000 abortions in Denmark, where abortion may be performed later in pregnancy and is relatively more frequently done for serious medical disease.

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Mortality with Contraception and Induced Abortion

THE following paper was written by Christopher Tietze, M.D., Associate Director, Bio-Medical Division, The Population Council. We are pleased to be able to present it here.

AN unwanted pregnancy can be avoided by the use of contraception; an unwanted birth, by induced abortion. Since the ultimate objectives are identical, it is appropriate to compare the two approaches in terms of the risks to the woman's life associated with their use. This can be done by means of a statistical model, based on 100,000 women of reproductive age in fertile unions and exposed to the risk of pregnancy, assuming the following rates of mortality.

1. *Maternal Mortality* from complications of, or associated with, pregnancy, childbirth, and the puerperium, *excluding induced abortion: 20 deaths per 100,000 pregnancies*. This rate corresponds to the current level of maternal mortality in the white population in the United States. Official statistics of maternal mortality in the United States are based only on deaths attributed to complications of pregnancy, childbirth, and the puerperium. Thus defined, the rate of maternal mortality, excluding abortion, was 18 per 100,000 live births in 1964–66.

"Associated" deaths, related to pregnancy and childbirth, but attributed to other causes, e.g., heart disease, are not available for the United States. In England, where such associated deaths are identified and shown separately, they comprise about one-third of the number of deaths attributed to complications of pregnancy, childbirth, and the puerperium. Raising the maternal mortality rate for the U.S. by one-third brings it to 24 per 100,000 live births. Since the number of spontaneous fetal deaths appears to be on the order of one-sixth of all pregnancies and since very few deaths result from spontaneous abortion, an overall risk to life, excluding induced abortion, of 20 per 100,000 pregnancies would seem to be a reasonable approximation.

2. *Mortality* associated with *illegal abortion* induced out of hospital by persons without medical training: *100 deaths per 100,000 abortions*. This is a very rough estimate, and, almost certainly conservative, since it is lower than the maternal mortality rate, excluding abortion, per 100,000 live births for white women in the United States 25 years ago. Fortunately, the precise level of this rate is not relevant to the argument.

3. *Mortality* associated with *legal abortion* performed in hospital, at an early stage of gestation: *3 deaths per 100,000 abortions*, based on current statistics from eastern Europe (73 deaths among 2,567,000 legal abortions in Czechoslovakia, Hungary, and Slovenia, 1957–67).[1]

4. *Mortality* associated with *highly effective contraception: 3 deaths per 100,000 users per year*, based on the studies recently published in Great Britain, on *excess mortality from thromboembolic disease* attributable to the use of *oral contraceptives*. According to the report by Inman and Vessey,[2] the excess mortality from pulmonary embolism, cerebral thrombosis, and coronary thrombosis was 2.2 and 4.5 per 100,000 users for women 20–34 and 35–44 years of age, respectively. A weighted average of these two figures yields an annual excess risk to life of about 3 per 100,000 users.

Line 1 of Table 1 illustrates the reproductive behavior of a group of women neither using contraception nor having recourse to induced abortion.

The interval between two successive conceptions consists of three segments: the period of gestation (G), the anovulatory period following confinement (A), and the average number of ovulatory cycles required for a new conception to occur (O).[3] Of these three segments, the first (G) can be estimated within narrow limits as eight months, allowing for about 15 per cent spontaneous abortions. The anovulatory period (A) is known to vary widely, depending on the extent and average duration of breastfeeding. The present model allows for a range from 4 months without breastfeeding to 14 months with universal and prolonged breastfeeding. The mean value for the third segment (O), also estimated at eight months, may be too high.

The relationship between the number of pregnancies (P and P'), the number of women (W), the time factor (T), and the duration of the three segments of the in-

[1] C. Tietze, "Abortion Laws and Abortion Practices in Europe," *Advances in Planned Parenthood (v.5): Proceedings of the Seventh Annual Meeting of the American Association of Planned Parenthood Physicians, San Francisco, California. 9–10 April 1969.* (In press).

[2] W.H.W. Inman and M.P. Vessey, "Investigation of Deaths from Pulmonary and Cerebral Thrombosis and Embolism in Women of Child-bearing Age," *British Medical Journal*, 2:193–199. 27 April 1968.

[3] R.G. Potter, "Birth Intervals: Structure and Change," *Population Studies*, 17:155–166. November 1963.

TABLE 1. *Illustrative Annual Rates of Pregnancies and of Deaths Associated with Contraception, Pregnancy, and Induced Abortion per 100,000 Women of Reproductive Age in Fertile Unions*

	Pregnancies	Deaths
1. No contraception, no induced abortion	40,000–60,000	8–12
2. No contraception, all pregnancies aborted out of hospital	100,000	100
3. Ditto, aborted in hospital	100,000	3
4. Highly effective contraception	100	3
5. Moderately effective contraception, no induced abortion	11,800–13,000	2.5
6. Ditto, all pregnancies aborted out of hospital	14,300	14.3
7. Ditto, aborted in hospital	14,300	0.4

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terval between conceptions (G, A, and O) is defined by the following formula:

$$P = \frac{W \times T}{G + A + O}$$

In our model, T equals 12 months and G, A, and O are also expressed in months. The application of the formula to the estimate described in the preceding paragraph yields the following results:

$$P = \frac{100{,}000 \times 12}{8 + 4 + 8} = \frac{1{,}200{,}000}{20} = 60{,}000$$

$$P' = \frac{100{,}000 \times 12}{8 + 14 + 8} = \frac{1{,}200{,}000}{30} = 40{,}000$$

Thus, without contraception or induced abortion, 100,000 women experience in the course of one year between 40,000 and 60,000 pregnancies, corresponding to average intervals between conceptions ranging from 30 months to 20 months. Given the level of maternal mortality, excluding abortion, assumed for this model, of 20 per 100,000 pregnancies, the 100,000 women would experience between 8 and 12 deaths associated with the reproductive process.

Line 2 assumes no contraception, but all pregnancies are aborted out of hospital. Because gestation and the post-gestational anovulatory period are both substantially shorter than under the assumptions of the preceding line (G = 3 months, A = 1 month), the number of pregnancies rises to 100,000 with 100 deaths:

$$P = \frac{100{,}000 \times 12}{3 + 1 + 8} = \frac{1{,}200{,}000}{12} = 100{,}000$$

In line 3, the same number of abortions is performed legally in hospitals, resulting in 3 deaths instead of 100.

Line 4 assumes a highly effective method of contraception, such as the consistent use of oral anti-ovulants under the combined regimen. The expected number of pregnancies is on the order of 100.[4] Excess deaths from thromboembolic disease equal those resulting from legal abortions in hospitals, shown on the preceding line. Because of the small number of pregnancies, mortality associated with either pregnancy and childbirth or with abortion is insignificant.

A comparison of lines 3 and 4 shows that women regulating their fertility exclusively by means of abortions performed in hospitals are exposed to a risk to life of the same order of magnitude as an equal number of women using oral contraception consistently over the same period of time.

Lines 5, 6, and 7 each assumes a less effective but completely safe type of contraception which extends the average duration of ovulatory exposure required for conception from 8 to 80 months. This level of contraceptive effectiveness was approximately achieved by urban American couples in the 1950's, using the diaphragm or condoms, mainly for child spacing, and not for family limitation.[5]

Line 5 assumes no induced abortions and the number of conceptions is computed as follows:

$$P = \frac{100{,}000 \times 12}{8 + 4 + 80} = \frac{1{,}200{,}000}{92} \cong 13{,}000$$

$$P' = \frac{100{,}000 \times 12}{8 + 14 + 80} = \frac{1{,}200{,}000}{102} \cong 11{,}800$$

The corresponding number of deaths is on the order of 2.5 per 100,000 women per year.

Line 6 assumes that all pregnancies are aborted out of hospital by lay abortionists. The number of pregnancies increases slightly, owing to the shorter gestation and post-gestational anovulatory periods.

$$P = \frac{100{,}000 \times 12}{3 + 1 + 80} = \frac{1{,}200{,}000}{84} \cong 14{,}300$$

The expected number of deaths is 14.3 per 100,000 women per year.

In line 7, the same number of abortions is performed legally in hospitals and the number of deaths drops to 0.4 per 100,000 women or approximately one-seventh of the corresponding values shown in line 3 for no contraception but legal abortion, and in line 4, for oral contraception.

On the basis of this model, the following is my conclusion: In terms of the risk to life, the most rational procedure for regulating fertility is the use of a perfectly safe, although not 100 per cent effective, method of contraception and the termination of pregnancies resulting from contraceptive failure under the best possible circumstances, i.e., in the operating room of a hospital.

While comparable estimates of morbidity, associated with pregnancy and childbirth, abortion out of hospital and in hospital, and oral contraception, are not available, it is not unlikely that the pattern would be similar to that which has been demonstrated in terms of mortality.

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[4] C. Tietze, "Oral and Intrauterine Contraception: Effectiveness and Safety," *International Journal of Fertility*, 13 (4):377–384. October–December 1968.

[5] P.C. Sagi, R.G. Potter, C.F. Westoff, "Contraceptive Effectiveness as a Function of Desired Family Size," *Population Studies*, 15:291–296. March 1962.



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Item No. 52

ABORTION LAWS AND ABORTION PRACTICES IN EUROPE

CHRISTOPHER TIETZE*

Legislation regulating abortion in Europe runs the gamut from complete prohibition in Belgium and Ireland to abortion on request in Hungary and the U.S.S.R.[1] In a number of countries, *de facto* practice is more permissive than the indications recognized *de jure*. As shown in Table I, listing all countries with more than one million inhabitants and based in part on a compilation by Hubinont[2], the predominantly Catholic countries of western and southern Europe have the most restrictive legislation. Where artificial termination of pregnancy is not entirely prohibited, it is permitted for the single purpose of saving the woman's life or on narrowly interpreted medical indication, *i.e.*, to avert a serious threat to the woman's health, without consideration of the circumstances under which she has to live. In a few countries, eugenic and/or humanitarian indications are also recognized, at least *de facto*. Generally, therapeutic abortion is done rarely and with reluctance, but this is not universally true and in a few cities, notably in Switzerland, the practices of the medical profession are very liberal.[3, 4]

Northern Europe[5]

The first countries in Europe to take steps toward the liberalization of their abortion laws were Iceland, Sweden, and Denmark, during the 1930's. After World War II, Sweden in 1946 and again in 1963,[6] and Denmark in 1956,[7] further revised their abortion laws. Finland passed a liberal abortion statute in 1950[8] and Norway in 1960.[9] In the latter country, the new law merely codified what had long been accepted medical practice.

The range of acceptable indications is roughly the same in Sweden, Norway, Denmark and Finland. In each instance the law recognizes a medical indication, a eugenic indication, and a humanitarian indication. The scope of the medical indication has been explicitly extended to include considerations of a mixed socio-medical character. The wording of the Danish statute of 1956 will serve as an example. Under this statute, termination of pregnancy is permitted 'if the induction of an abortion is necessary to avert a serious danger to the life or health of the woman. In order to evaluate this danger, an appreciation shall be made of all the circumstances of the case, including the conditions under which the woman will have to live, and consideration shall be given not only to physical or mental illness, but also to any actual or potential state of physical or mental infirmity'.[7]

In regard to the eugenic indication, the older statutes mention only the hereditary transmission of mental disease, mental deficiency, and other severe illness or defect. Sweden's Royal Medical Board, however, has authorized the termination of pregnancy on psychiatric indication in many cases of German measles and in at least one celebrated case of thalidomide use.[10, 11] The 1963 amendment to the Swedish law and the new Danish and Norwegian statutes extend the traditional eugenic indication to cover damage or disease acquired during intra-

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TABLE I

Abortion laws and abortion practices in Europe, 1969

	Recognized indications	De jure	De facto
I	Absolute prohibition	Belgium* Ireland	Ireland
II	Threat to woman's life	Albania Austria* Italy Netherlands* Portugal Spain	Albania Italy Portugal Spain
III	Medical	France German Fed. Rep. Switzerland*	Austria* France German Fed. Rep.
IV	Medical, eugenic, and/or humanitarian	German Dem. Rep.* Greece Rumania* (1)	Belgium* Greece Netherlands*
V	Medical-social and eugenic	Great Britain	Great Britain Switzerland*
VI	Medical-social, eugenic, and humanitarian	Denmark Finland Norway Sweden	Denmark Finland German Dem. Rep.* Norway Rumania* (1) Sweden
VII	Medical, eugenic, humanitarian, and social	Czechoslovakia Poland* Yugoslavia	Czechoslovakia Yugoslavia
VIII	On request	Bulgaria (2) Hungary U.S.S.R.	Bulgaria Hungary Poland* U.S.S.R.

* *De facto* practice more permissive than *de jure* indications.

1. The *de jure* position for women 45 years of age and over and those with four or more children is in Group VIII. Information on the *de facto* position is fragmentary but the reported number of abortions suggests Group VI.

2. For childless women the *de jure* position is Group VII.

uterine life. The humanitarian indication applies to pregnancies resulting from offenses against the penal code, such as forcible and statutory rape, as well as incest.

With minor exceptions, the maximum period of gestation at which abortion is permissible is five months in Sweden, four months in Denmark and Finland, and three months in Norway.

Examination of the administrative machinery implementing the abortion statutes in these four countries of northern Europe reveals important differences. The procedure is most centralized in Sweden, where, until 1965, more than 85 percent of all legal abortions were authorized by the Royal Medical Board in Stockholm, which makes its decision on the basis

of a written report from the physician who has examined the woman seeking abortion. The remaining 15 percent of the terminations were performed on the authority of a certificate signed by two physicians. The latter type of authorization accounted for one-fourth of all cases in 1966 and about one-third in 1967, possibly indicating a greater willingness on the part of Swedish doctors to accept responsibility for the decision.

In Denmark, most legal abortions require the unanimous authorization of a committee of three persons, attached to the local Mothers' Aid, a publicly supported organization, which conducts a thorough medical and social investigation. Twenty such committees have been established throughout the country, including five in Greater Copenhagen, each consisting of a psychiatrist, a gynecologist, and a social worker. Abortion on purely medical indications, where the threat to life and health results from a disease and not from the conditions under which the woman lives, may be performed on the sole authority of the appropriate chief of service. These cases represent about one-tenth of the total number of legal abortions in Denmark.

In Finland and Norway, the administrative machinery is relatively decentralized, with most legal abortions approved by two physicians, one of whom must be a gynecologist or surgeon on the permanent staff of a hospital. In Finland, the other physician is drawn from a roster of medical specialists established by the State Medical Board; in Norway, he is appointed by the county health officer and must be trained in psychiatry or social medicine.

In recent years, commissions of experts to re-evaluate the abortion question have been appointed in Sweden, Denmark, and Finland. The report of the Danish commission was published in early 1969.[12] A majority of its members rejected abortion on request, at least 'for the time being', but recommended four new indications for the interruption of pregnancy: Advanced age ('If the woman has completed her thirty-eighth year prior to the end of the twelfth week of pregnancy'), multiparity ('If the woman has given birth to at least four children who live at home and are under eighteen years of age'), immaturity ('If the woman, because of her youth or immaturity, cannot for the time being take care of the child in a responsible manner'), and social stress ('If pregnancy, childbirth, or care for the child may be assumed to result in severe stress on the woman, which cannot be averted in any other way, so that termination of pregnancy is considered necessary in consideration of the woman, the maintenance of the home, or the care of other children in the family'). H. Hoffmeyer, in a minority report, supported abortion on request for all women. The committee also recommended that the maximum period of gestation at which a pregnancy may be terminated be reduced from sixteen weeks to twelve weeks.

The reports of the Swedish and Finnish commissions are not yet available for analysis. Because it is known that the Swedish commission was given a mandate for a further liberalization of the indications for abortion, its recommendations and the resulting action of the legislature, if any, are expected with keen anticipation.

Legal abortions in Sweden increased from less than 0.1 per 1,000 population in 1939, following the enactment of a liberalized abortion law, to 0.9 per 1,000 in 1951, after which the trend was reversed, and the abortion rate dropped below 0.5 per 1,000 during the seven years 1957–63 (Table II and Figure 1), although the upward trend was resumed in 1961. Five years later the abortion rate surpassed the high point of the early 1950's and in 1967 it reached a peak of about 1.2 abortions per 1,000 population.[13] The course of events in Denmark was roughly parallel to that in Sweden, on a higher level, at least until 1966.[14]

In Sweden about 35 percent of the women undergoing legal abortion in 1964–65 were single, 55 percent were married, and 10 percent were widows or divorcees. About 75 percent had previously given birth, including 10 percent with five or more children.[15] In Denmark the proportions of married women (79 percent), parous women (89 percent), and mothers of five or more children (12 percent) were higher, but there were relatively fewer single women (14 percent) and previously married women (7 percent).[12a] These statistics are based, respec-

TABLE II

Legal abortions in Sweden, 1939–67, and Denmark, 1939–66

Year	Number		Rate per 1,000 population	
	Sweden	Denmark	Sweden	Denmark
1939	439	484	.07	.13
1940	506	522	.08	.14
1941	496	519	.08	.13
1942	568	824	.09	.21
1943	703	977	.11	.25
1944	1,088	1,286	.17	.32
1945	1,623	1,577	.24	.39
1946	2,378	1,930	.35	.47
1947	3,534	2,240	.52	.54
1948	4,585	2,543	.67	.61
1949	5,503	3,425	.79	.81
1950	5,889	3,909	.84	.92
1951	6,328	4,743	.90	1.10
1952	5,322	5,031	.75	1.16
1953	4,915	4,795	.69	1.10
1954	5,089	5,140	.71	1.17
1955	4,562	5,381	.63	1.21
1956	3,851	4,522	.53	1.01
1957	3,386	4,023	.46	.90
1958	2,823	3,895	.38	.86
1959	3,071	3,587	.41	.79
1960	2,792	3,918	.37	.86
1961	2,909	4,124	.39	.89
1962	3,205	3,996	.42	.86
1963	3,528	3,971	.46	.85
1964	4,671	4,527	.61	.96
1965	6,208	5,188	.80	1.09
1966	7,254	5,726	.93	1.19
1967	9,600*	NA	1.22	NA

* Preliminary.
NA = Not available.

tively, on abortions approved by the Royal Medical Board in Sweden and the Mothers' Aid organization in Denmark; abortions authorized by two physicians (Sweden) or by the chief of service (Denmark) are excluded.

In Norway, two special surveys established the numbers of abortions performed in hospitals at about 0.6 per 1,000 population in 1949 and 0.9 per 1,000 in 1954.[15] After the law of 1960 had become operative in February, 1964, the abortion rate increased to 1.2 per 1,000 population in 1966.[12b]

In Finland, legal abortions rose from about 0.7 per 1,000 population in 1951 to 1.4 per 1,000 in 1960. Over the next five years a decline to 1.0 per 1,000 was recorded.[16] In Iceland, according to unpublished data furnished by the Ministry of Health, legal abortions averaged slightly more than fifty per year during the decade 1954–63 without a discernible trend; this figure corresponds to 0.3 abortions per 1,000 population.

The overwhelming majority of legal abortions in northern Europe are performed on

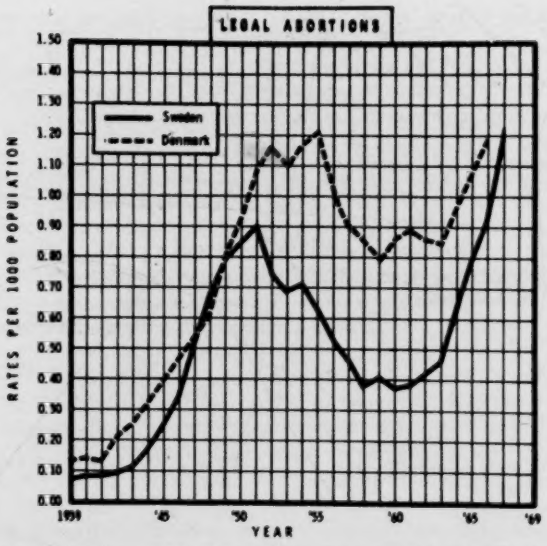


Fig. 1. Legal abortions per 1,000 population: Sweden and Denmark, 1939–67.

medical indication and, most often, on psychiatric grounds. The eugenic and humanitarian indications play very minor roles.

One of the major goals of the liberalization of abortion statutes in northern Europe was to reduce the incidence of illegal abortion. A further objective was to reduce the total number of abortions, legal and illegal combined, by establishing early contact with the pregnant woman and making available to her a broad range of social services. There is no agreement among Scandinavian authors as to what extent the first of these objectives has been achieved, and it is even less likely that the second goal has been realized in any of the countries concerned.[17–21] Whether the abortion laws have actually contributed to what has been referred to as 'abortion mentality' is a much debated question.

A by-product of the liberal laws of northern Europe has been the compilation of nation-wide statistics on mortality associated with legal abortion (Table III). The longest continuous

TABLE III

Mortality with legal abortion: Sweden, 1946–66 and Denmark, 1940–65

Country and period	Legal abortions	Deaths	Rate per 100,000
Sweden			
1946–48	10,500	27	257
1949–53	28,000	27	96
1954–59	22,800	15	66
1960–66	30,600	12	39
Denmark			
1940–50	19,500	38	195
1953–57	23,700	16	68
1961–65	21,700	9	41

series is available for Sweden, where there has occurred, over two decades, a marked and gratifying decline in mortality.[13, 23] A comparable series of statistics for Denmark extends over an even longer period but with two breaks in continuity.[23-25] Deaths attributable to pre-existing conditions, as well as those resulting from the operation, are included in these statistics. For Finland, eighteen deaths were reported among 27,100 legal abortions in 1950-57, corresponding to a rate of 66 per 100,000.[26]

Early complications of legal abortions reported in Denmark[25] during the period 1961-65 are shown in Table IV. Late somatic complications among women who had legal abortions

TABLE IV

Early complications of legal abortions: Denmark, 1961-65

	Number	Rate per 1,000
Bleeding*	243	11
Adnexitis**	201	9
Fever	199	9
Perforation of uterus	69	3
Rupture of wound	33	1.5
Phlebitis	33	1.5
Endometritis	27	1.2
Pneumonia	19	0.9
Pulmonary infarction	14	0.6
Injury to cervix	14	0.6
Ileus	12	0.6
Shock	8	0.4
Peritonitis	7	0.3
Sepsis	5	0.2
Other	7	0.3

* Including 91 cases of repeat evacuation presumably because of bleeding.

** Including oophoritis, salpingitis, and parametritis.

have been comprehensively surveyed by Lindahl.[27] Ekblad and others have studied the mental and emotional sequelae among women who had legal abortions,[28, 29] women whose abortion was approved but not carried out,[30] and those whose application was refused,[31] as well as among their children.[32]

United Kingdom

The most recent addition to the roster of countries with extended indications for legal abortion is Great Britain. According to the common law, which is the basis of the British legal system, abortion prior to quickening was not a crime, while abortion after quickening was considered a misdemeanor.[33] In 1803, abortion was made a statutory offense and a felony, although its performance was less severely punished prior to quickening than after quickening.

The Offenses Against the Person Act, enacted in 1861, made 'unlawfully' induced abortion a felony punishable by life imprisonment. The Act did not define 'unlawfully' and made no provision for the therapeutic termination of pregnancy. However, in 1938, in the famous case of *Rex* vs. *Bourne*, Mr. Justice Macnaughten ruled that abortion need not be unlawful if done in good faith to preserve the mother's life. He further instructed the jury as follows: 'If the doctor is of the opinion . . . that the probable consequences . . . will be to make the woman a

physical and mental wreck, the jury is quite entitled to take the view that the doctor . . . is operating for the purpose of preserving the life of the mother'. Bourne, who had aborted a young girl who had been the victim of a gang-rape attack, was acquitted and a legal precedent was set.[34]

Nevertheless, the official attitude and practice of the British medical profession remained basically conservative, especially in regard to non-private patients. About 1,570 therapeutic abortions were performed in the National Health Service (NHS) hospitals in England and Wales in 1958, rising to 2,830 in 1962 and to 6,380 in 1966. Over the same period, the abortion rate rose from 0.03 to 0.06 to 0.13 per 1,000 population. Women able to pay the customary fee of 100 guineas ($ 290) or more found it notably easier to obtain abortions, especially in London. The total number of therapeutic abortions, including a minimum estimate of those performed in private practice, increased to about 21,000 in 1966.[35] The latter figure corresponds to a rate of about 0.4 per 1,000 population.

In October, 1967, after a long and bitter legislative struggle,[36, 37] Parliament enacted a liberalized abortion statute, authorizing abortion if two physicians '. . . are of the opinion, formed in good faith: that the continuance of the pregnancy would involve risk to the life of the pregnant woman or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped'.[38] The Act provides further that 'in determining whether or not there is such risk of injury to health, account may be taken of the pregnant woman's environment both at the time when the child was born and thereafter so far as foreseeable.' Abortions may be performed in NHS hospitals or in facilities approved by the Minister of Health. The latter category includes private nursing homes. Conscientious objectors are specifically excused from participating in abortion procedures. The Act applies to England, Wales, and Scotland, but not to Northern Ireland; it came into force on April 27, 1968, after the appropriate regulations had been issued.[39] Guidelines for physicians in evaluating medical indications have been published by the British Medical Association.[40]

The British Abortion Act of 1967 contains a number of revolutionary innovations. Potentially most important are the words 'greater than if the pregnancy were terminated,' qualifying the 'risk to life or of injury to physical or mental health' of a continuing pregnancy. While this clause was inserted at a late stage of the legislative process, at the request of opponents of liberalization, it has been interpreted as justifying abortion in order to secure a relatively small improvement in the woman's medical condition, since at least the risk to life associated with early abortion under favorable conditions is substantially less than the risk normally associated with pregnancy and childbirth.[41]

Another important passage are the seven words 'or any existing children of her family'. Couched in medical terms, this phrase constitutes a recognition of the fact that not only the mother but her entire family may be adversely affected by the birth of an unwanted child. It should also be noted that the Act does not establish administrative machinery to authorize the termination of pregnancy. Any two physicians can make the determination if they feel that the required conditions are met.

A definitive evaluation of the new British abortion statute will not be possible for some time. During the first year of operation of the Act about 37,700 abortions were reported in England and Wales, including 22,500 in the NHS hospitals and about 15,200 in private practice. It would appear, then, that the number of therapeutic abortions under the NHS has more than tripled, as compared with 1966, while the total for England and Wales has increased to a level of 0.8 legal abortions per 1,000 population. Of the women undergoing abortion, about 48 percent were single, 44 percent were married, and 8 percent widowed, divorced, or separated.[42]

The trend of legal abortions in Britain in the years to come will depend largely on the

attitude of the medical profession. At present, resistance to abortion is often encountered, especially outside of London. One of the major centers of opposition is Birmingham. In one of the city's NHS hospitals, both consultants in obstetrics are Roman Catholics, who do not perform abortions. They are said to refer applicants to another hospital where the chief of the obstetric service has recently boasted that only one abortion was performed on his service in the course of a year. The psychiatrist at the same hospital is Dr. Myre Sim, who feels that 'there are no psychiatric grounds for the termination of pregnancy' and who moved the resolution against abortion reform at the conference of the British Medical Association in 1967.[43] In response to this situation, which makes it impossible for sympathetic general practitioners to refer their patients to local hospitals, a group of physicians and other professional workers have formed the Birmingham Pregnancy Advisory Service, which counsels women on whether they have lawful grounds for abortion, and if they have, tries to help them obtain it. The group hopes to start its own abortion center.[44] Similar groups may be organized in other cities.

Although statutes and practices relating to abortion are much more liberal in northern Europe and in Britain than in the majority of European countries or in the United States, abortion has, in fact, been 'legalized' on limited grounds only. Several of the socialist countries in eastern Europe have adopted far more radical policies.

Eastern Europe[45-48]

In eastern Europe, abortion policy has undergone several major changes since 1920, when interruption of pregnancy at the request of the pregnant woman was legalized in the U.S.S.R. by a joint decree of the Commissariats of Health and Justice. In 1936, another decree restricted legal abortion to a list of specified medical and eugenic indications. In 1955, the policy was once more reversed and the restrictive decree of 1936 repealed by the Presidium of the Supreme Soviet.[49]

Following the example of the U.S.S.R., all the socialist countries of eastern Europe, except East Germany and Albania, adopted similar liberalizing legislation.[50-51] In the words of the preamble to the Soviet decree, the aims of this legislation are 'the limitation of the harm caused to the health of women by abortions carried out outside hospitals', and to 'give women the possibility of deciding themselves the question of motherhood.'

Throughout eastern Europe, official concern with overpopulation or rapid population growth is proscribed by Marxist philosophy. Moreover, several of the countries concerned have very low birth rates, and none has a high birth rate by global standards. At least two countries, Czechoslovakia and Hungary, have long pursued an active population policy by means of family allowances for third and later children.

Within the overall pattern of legal abortion, considerable variation between individual countries is apparent. Abortion at the request of the pregnant woman was legalized in the U.S.S.R., Bulgaria, Hungary, and Rumania. In Poland, the law of 1956 stipulates a 'difficult social situation' as an acceptable reason for the termination of pregnancy. In Czechoslovakia, the law permits abortion for reasons 'which deserve special consideration', among which the Ministry of Health listed in 1957: *(a)* advanced age, *(b)* numerous children, *(c)* loss or disability of husband, *(d)* broken home, *(e)* predominant economic responsibility of the woman for the maintenance of the family or the child, *(f)* difficult circumstances of an unmarried woman resulting from her pregnancy, and *(g)* pregnancy due to rape or other offense. Late in 1961, a new regulation restricted voluntary abortions on the ground of multiparity to women with three or more living children, and also required a threat to the level of living in cases of predominant economic responsibility of the woman.[52] In Yugoslavia, termination of pregnancy may be authorized if the birth of the child would result in a serious personal, familial, or economic situation for the pregnant woman which cannot be averted in any other way.

Commissions for the authorization of abortion, consisting of physicians and representatives of the social services, have been established in Czechoslovakia and Yugoslavia. Medical boards also exist in Hungary, but their function has become purely formal since they must assent if the applicant insists on having her pregnancy terminated. In Poland, abortion is authorized by a certificate from a single physician.

Throughout eastern Europe abortion is prohibited in cases of pregnancy of more than three months' duration, except for medical reasons, and also if the applicant has undergone an induced abortion during the preceding six months. In some countries, such as Czechoslovakia and Hungary, the operation must be performed in an appropriately equipped and staffed hospital, where the typical period of stay is two or three days followed by sick leave if the woman is a wage earner. In Poland and Yugoslavia, however, many legal abortions are done on ambulatory patients. In recent years, suction curettage has been used on an increasing scale throughout eastern Europe because it is technically easier, faster, and less traumatic than the traditional 'D & C'.[56, 57]

The last few years have brought important changes in the abortion laws and practices of some countries in eastern Europe. These changes took place in East Germany, Rumania, and Bulgaria.

The German Democratic Republic did not participate in the general liberalization of abortion laws during the 1950's. After World War II the draconic regulations of the Third Reich were replaced by a series of State laws under which legal abortion could be performed on medical, eugenic, and humanitarian grounds, and to some extent on social or economic grounds also. These statutes were in turn superseded in 1950 by the Law for the Protection of the Mother and the Child, which permits abortion on medical and eugenic indication only. The decision lies with regional commissions which include among their members not only physicians but also representatives of the social services and the quasi-official Union of German Women.[58, 59] In 1965, these commissions were administratively authorized to extend the scope of the medical indication, taking into account the woman's social environment.[60] Since statistics on legal abortions in the German Democratic Republic have not been published since 1962,[61] the effect of this administrative action cannot be evaluated.

The changes in Rumania and Bulgaria were in the opposite direction. In both countries, abortion on request, to be performed without any formalities in any hospital, had been legalized in 1956–57. Rumania abruptly reversed this policy by a decree issued in October, 1966, restricting abortion to women over forty-five years of age and to mothers supporting four or more living children, in addition to the usual medical, eugenic, and humanitarian indications.[62] The medical indication is narrowly defined as a threat to the woman's life. The preamble to the decree of 1966 refers to the 'great prejudice to the birth rate and the rate of natural increase' resulting from the practice of abortion as well as to 'severe consequences to the health of the woman'. It would appear, however, that the primary reason for the repeal of the law of 1957 was concern over the decline in the birth rate, which by 1966 had dropped to 14.3 per 1,000 population, the second lowest in Europe.

In the case of Bulgaria, the change was far less drastic than in Rumania. According to a regulation issued in February, 1968, interruption of pregnancy is prohibited in the case of a woman without a living child, except in the presence of a serious medical or social indication, established by a women's health center.[63]

Women with one or two children must apply to a board which 'shall explain the harmfulness and dangers of abortion, the need to take the pregnancy to full term, the financial support which the family will receive after the birth of the child and, in general, shall make every effort to dissuade every woman who expresses the desire to have her pregnancy interrupted from doing so'. If, nevertheless, the woman persists in asking for the termination of her pregnancy, the board must give its approval. Women over forty-five years of age and those with three or more children do not require the approval of the above-mentioned board.

TABLE V

Births and abortions in Czechoslovakia, 1953–67, Hungary, 1950–67, and Slovenia, 1955–67: numbers and rates

Year	Number in 1,000's			Rate per 1,000 population		
	Live births	Legal abortions	Other abortions*	Live births	Legal abortions	Other abortions*
1953 *Czechoslovakia*	271.7	1.5	29.1	21.2	0.1	2.3
1954	266.7	2.8	30.6	20.6	0.2	2.4
1955	265.2	2.1	33.0	20.3	0.2	2.5
1956	262.0	3.1	31.0	19.8	0.2	2.3
1957	252.7	7.3	30.2	18.9	0.5	2.3
1958	235.0	61.4	27.7	17.4	4.6	2.1
1959	217.0	79.1	26.4	16.0	5.8	1.9
1960	217.3	88.3	26.3	15.9	6.5	1.9
1961	218.4	94.3	26.0	15.8	6.8	1.9
1962	217.5	89.8	26.1	15.7	6.5	1.9
1963	236.0	70.5	29.4	16.9	5.0	2.1
1964	241.1	70.7	28.5	17.1	5.0	2.0
1965	231.6	79.6	26.2	16.4	5.6	1.8
1966	222.5	90.3	25.5	15.6	6.3	1.8
1967	217.4	95.1	24.4	15.1	6.6	1.7
1950 *Hungary*	195.6	1.7	34.3	20.9	0.2	3.7
1951	190.6	1.7	36.1	20.2	0.2	3.8
1952	185.8	1.7	42.0	19.6	0.2	4.4
1953	206.9	2.8	39.9	21.6	0.3	4.2
1954	223.3	16.3	42.0	23.0	1.7	4.3
1955	210.4	35.4	43.1	21.4	3.6	4.4
1956	192.8	82.5	41.1	19.5	8.3	4.2
1957	167.2	123.4	39.5	17.0	12.5	4.0
1958	158.4	145.6	37.4	16.0	14.7	3.8
1959	151.2	152.4	35.3	15.2	15.3	3.5
1960	146.5	162.2	33.8	14.7	16.2	3.4
1961	140.4	170.0	33.7	14.0	17.0	3.4
1962	130.1	163.7	33.9	12.9	16.3	3.4
1963	132.3	173.8	34.1	13.1	17.2	3.4
1964	132.1	184.4	34.3	13.1	18.2	3.4
1965	133.0	180.3	33.7	13.1	17.8	3.3
1966	138.5	186.8	33.6	13.6	18.3	3.3
1967	148.9	187.5	34.9	14.6	18.4	3.4
1955 *Slovenia*	32.1	0.4	5.0	21.0	0.3	3.3
1956	31.5	0.8	4.6	20.4	0.5	3.0
1957	30.1	2.2	5.6	19.4	1.4	3.6
1958	28.2	4.7	6.0	18.1	3.0	3.8
1959	28.4	6.4	5.2	18.2	4.1	3.3
1960	27.8	8.2	5.5	17.6	5.2	3.5
1961	29.0	9.3	5.6	18.2	5.8	3.5
1962	29.0	9.5	5.6	18.1	5.9	3.5
1963	29.2	9.4	6.1	18.1	5.8	3.8
1964	29.2	9.4	6.0	17.9	5.8	3.7
1965	30.7	9.9	6.1	18.6	6.0	3.7
1966	30.9	9.5	5.4	18.5	5.7	3.2
1967	29.6	10.1	4.3	17.5	6.0	2.6

* Hospital admissions.

This regulation was issued on the basis of a governmental decree for the encouragement of the birth rate. There is no question, therefore, that the retreat from abortion on request was motivated primarily by demographic considerations. The birth rate in Bulgaria was 14.9 per 1,000 population in 1966.

The liberalization of abortion laws in the 1950's resulted in spectacular increases in the incidence of legal abortion throughout eastern Europe. The most comprehensive and trustworthy statistics are those for Czechoslovakia, Hungary, and Slovenia, the most developed among the constituent republics of Yugoslavia (Table V). The U.S.S.R. has not published any statistics on abortion. There are reasons to believe, however, that the number is very large and the rate very high.[64]

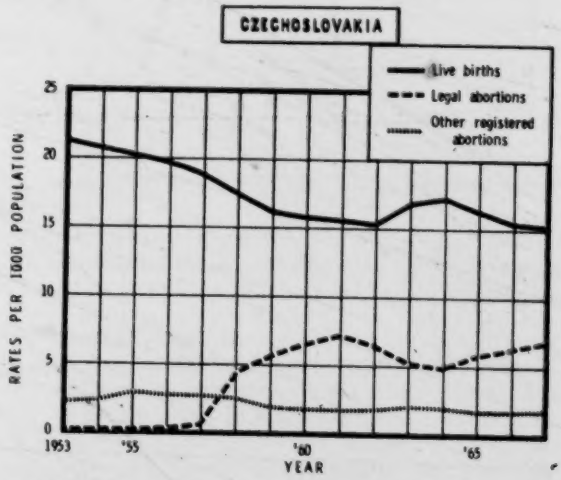


Fig. 2. Live births and abortions per 1,000 population: Czechoslovakia, 1953–67.

In Czechoslovakia (Figure 2), legalization of abortion for non-medical reasons was preceded by almost two years of public discussion. Moderate increases in the abortion rate in 1956 and 1957 reflect the changing attitude of the medical profession.[65] Promulgation of a new and liberalized abortion law in December, 1957, was followed by a steep rise in legal abortions in 1958, which continued at a decelerating pace until 1961, when the rate reached a peak of 6.8 per 1,000 population. The trend was then reversed with a drop to 5.0 per 1,000 in 1963, followed by a renewed upward movement two years later which has continued through 1967.[64, 67]

In Hungary (Figure 3), vigorous efforts to enforce existing laws against criminal abortion in 1952 and 1953 were followed by an increase in births in 1953 and 1954. At about the same time, medical boards for the authorization of therapeutic abortions were established. The growing numbers of legal abortions since 1953 indicate the progressive liberalization of the policies of these boards.[68] After the decree of June 3, 1956, had introduced termination of pregnancy on request, the rate of legal abortions increased rapidly until it reached 18.4 per 1,000 population in 1967, exceeding the birth rate by about one-fourth.[69]

In Slovenia, the rate of legal abortions approaches that found in Czechoslovakia; however, the decline seen in that country during the early 1960's is lacking.[70–72]

What has been the effect of legalization on the frequency of illegal abortions in Czecho-

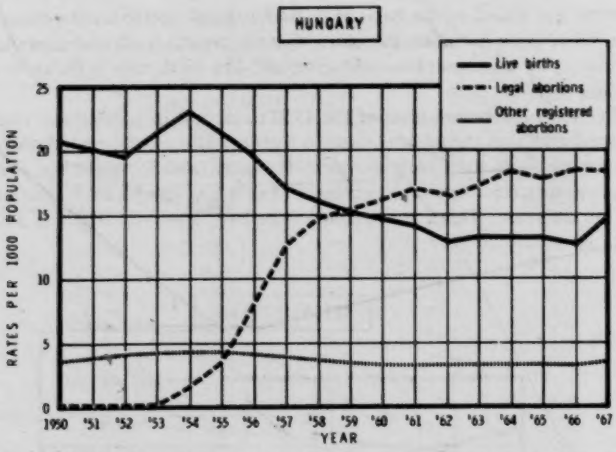


Fig. 3. Live births and abortions per 1,000 population: Hungary, 1950–67.

slovakia, Hungary, and Slovenia? This question cannot be answered with certainty since the number of illegal abortions is not known before the new legislation or at the present time. The reported numbers and rates of 'other abortions', limited to hospitalized cases, have declined moderately.

No firm conclusions can be drawn from this trend since these figures include spontaneous abortions as well as illegal abortions requiring hospitalization for aftercare or the treatment of complications. Moreover, neither the proportion reaching medical attention among all abortions, other than those legally performed in hospitals, nor the proportion hospitalized among those under medical care, may be assumed to have remained at constant levels. Deliveries in hospitals in Czechoslovakia increased from 79.4 percent of all deliveries in 1955 to 98.1 percent in 1966.[73] The corresponding proportions in Hungary were 67.0 percent in 1956 and 96.6 percent in 1965.[69a] To what extent this trend toward greater utilization of institutional facilities extends to the treatment of abortion is a matter of conjecture.

Mortality due to abortion, as reported in national cause-of-death statistics, declined rapidly in Czechoslovakia and Hungary after the enactment of liberal abortion statutes in the 1950's; such a change was not seen at that time in countries without new legislation, such as France or England (Figure 4). The declines are even more marked if the deaths associated with the rising numbers of legal abortions are excluded. It should be noted, however, that the level of abortion mortality in Hungary was still significantly higher, in spite of the downward trend, in the early 1960's than in western Europe, while in Czechoslovakia it was only slightly lower than in France or England.

In summary, then, there is little doubt that the number of criminal abortions has declined substantially but that these declines have been masked by increased hospitalization after spontaneous or illegal abortion, resulting in part from restrictions on the private practice of medicine and in part from the fact that women no longer fear prosecution or harassment by the police. Nevertheless, criminal abortion and/or self-abortion have not disappeared, even in Hungary, where abortion has been available on request for more than a decade. There is evidence that this stubborn survival of clandestine abortion is associated with the relative lack of privacy of the official procedure.[74]

'Other abortions' are reported more frequently in Hungary than in Czechoslovakia. According to Hirschler, the high rate reflects the practice of some gynecologists who admit

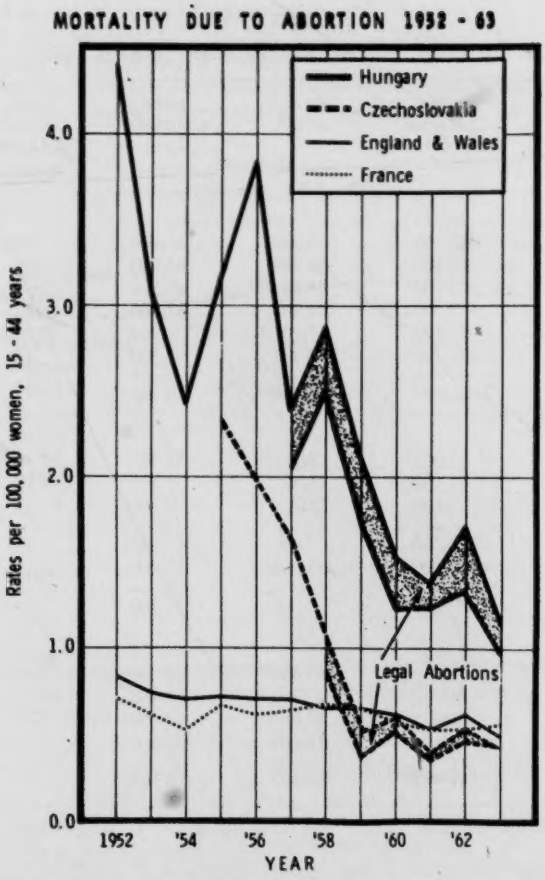


Fig. 4. Deaths attributed to abortion per 100,000 women, 15–44 years of age: Selected countries, 1952–63.

women to hospitals under the pretext of incomplete abortion in order to avoid charging the prescribed modest fee for abortion on request or because the women live outside the area from which the hospital may admit for this purpose.[75] There is no ready explanation for the relatively high rate of 'other abortions' in Slovenia.

According to the official statistics for 1965, two out of three women undergoing legal abortion in Czechoslovakia (67 percent) were between twenty and thirty-five years of age, compared with three out of four (74 percent) in Hungary.[67, 69] Even higher were the proportions of married women (82 percent in Czechoslovakia, 86 percent in Hungary) and of women who had one or more living children at the time of the abortion (88 percent in Czechoslovakia, 85 percent in Hungary). Table VI shows additional detail on these points for Hungary.

Rumanian statistics are fragmentary. According to reports in the literature, which could not be traced to an official source, 112,000 legal abortions were performed in 1958, the first full year after abortion on request was legalized, and 219,000 in 1959.[74] The corresponding

TABLE VI

Pattern of legal abortion by age, marital status and number of living children: Hungary, 1963–64

Age, marital status, and number of prior living children	Female population 15–49*	Live births*	Legal abortions*	Legal abortions per 1,000 females	Legal abortions per 1,000 live births
Age:					
15–19	382,700	16,300	11,400	30	700
20–24	364,100	52,900	44,000	121	830
25–29	349,100	35,300	49,500	142	1,400
30–34	370,700	17,900	41,800	113	2,300
35–39	383,100	7,700	23,900	62	3,100
40–49	631,300	2,200	8,500	13	3,900
15–49	2,481,000	132,300	179,100	72	1,350
Marital status:					
Single	585,000	NA	16,900	29	NA
Widowed	61,900	NA	1,100	18	NA
Divorced	73,600	NA	3,900	53	NA
Unmarried	720,500	7,000	21,900	30	3,100
Married	1,760,500	125,300	157,200	89	1,250
Total	2,481,000	132,300	179,100	72	1,350
Living children:					
None	NA	63,400	27,200	NA	430
1	NA	40,300	53,600	NA	1,330
2	NA	14,000	55,700	NA	4,000
3 or more	NA	14,600	42,600	NA	2,900
Total	2,481,000	132,300	179,100	72	1,350

* Female population: Estimate for 1/1/1964. Live births and legal abortions: Average of 1963 and 1964.
NA = Not available.

abortion rates were 6.2 and 12.0, respectively, per 1,000 population. For 1965, the Central Committee of the Rumanian Communist Party announced a total of 1,115,000 abortions, 58.6 per 1,000, but it is not clear whether this figure refers to legal abortions only or to all abortions.[77] No data are available for the intervening years, which makes it difficult to evaluate the truly extraordinary figure for 1965 which is four times the number of births.

Following the sudden reversal of policy in late 1966 the number of legal abortions in Rumania dropped precipitously. According to a report of a Danish mission visiting Rumania in late 1967, about 35,000 were performed during the first ten months under the new law.[13c] Over the same period, about 104,000 so-called spontaneous abortions were reported. The corresponding rates, computed for a full year, were 2.2 and 6.5, respectively, per 1,000 population. While the abortions reported as spontaneous doubtless include many that were illegally induced, the Rumanian authorities suggested that the high rate may reflect, at least in part, a true increase in incidence, resulting from anatomical damage by repeated induced abortions during the preceding years. It was stated that women admitted to hospitals from November 1966 through March 1967 had experienced, on the average, five prior abortions.

The Rumanian birth rate jumped from 14.3 per 1,000 population in 1966 to 38.4 in the third quarter of 1967, followed by a gradual decline, presumably reflecting increased recourse to contraception and/or illegal abortion.

Mortality associated with legal abortion has fallen to very low levels in eastern Europe (Table VII). In Czechoslovakia, thirteen deaths occurred among 413,000 abortions during

TABLE VII

Mortality with legal abortion: selected countries in Eastern Europe, 1957–67

Country and period	Legal abortions	Deaths	Rate per 100,000
Czechoslovakia			
1958–62	413,000	13	3.1
1963–67	406,000	10	2.5
Hungary			
1957–58	269,000	15	5.6
1960–63	670,000	22	3.3
1964–67	739,000	9	1.2
Slovenia			
1961–67	67,000	4	6.0
Total	2,564,000	73	2.8

the period 1958–62, corresponding to a rate of 3.1 deaths per 100,000 abortions. By 1963–67, mortality had dropped to 2.5 per 100,000.[78] Hungary reported a mortality rate of 5.6 per 100,000 abortions in 1957-58,[68] while the most recent figure is 1.2 deaths per 100,000 for 1964–67.[75] In Slovenia, which has the best statistical service among the constituent republics of Yugoslavia, four deaths were reported in 1961–67 among 67,000 legal abortions, corresponding to a rate of 6.0 per 100,000 cases.[79]

Mortality associated with legal abortion is substantially lower in eastern Europe than in northern Europe where rates of about 40 per 100,000 have been reported in recent years. The higher death rates in northern Europe may be attributed in part to the fact that a substantial proportion of legal abortions is performed after the third month of gestation.[25, 80-82] These late abortions contribute heavily to the total number of deaths; in eastern Europe almost all legal abortions are performed in the first trimester of pregnancy, with the majority in the second month. In addition, many women undergoing legal abortion in northern Europe are ill or at least in poor physical condition, while in eastern Europe the overwhelming majority are in good health.

Statistical information on morbidity associated with legal abortion is less complete than information on mortality, and it is very difficult to achieve comparability between countries and even between investigators in the same country.

One of the early studies from Czechoslovakia reported on 7,331 terminations of pregnancy performed in five hospitals, mainly by dilatation and curettage.[83] The rate of early complications was 34 per 1,000 abortions, including twenty cases of infection, ten cases of bleeding, and four injuries per 1,000 women. At about the same time, three Hungarian authors reported on 23,300 legal abortions in one county, including 13,458 in three large hospitals.[84] In the latter group, 32 per 1,000 women experienced early complications, mainly bleeding and fever, with rates in the three hospitals ranging from 7 to 54. In addition, twenty-one women per

1,000 had to be re-admitted within six weeks of the operation. Serious injury was reported in eleven cases per 1,000.

In recent years, the pattern of early morbidity appears to have improved, although serious problems of statistical comparability remain. Table VIII summarizes Hirschler's countrywide

TABLE VIII

Early complications of legal abortions: Hungary, 1960–67

Type of complication	Rate per 1,000	
	1960–63	1964–67
Perforation of uterus	1.3	1.0
Fever of gynecologic origin	4.8	4.0
Hemorrhage after the abortion	6.3	6.6
Readmission for fever*	5.0	4.5
Readmission for hemorrhage*	11.2	10.0

* Within four weeks after the abortion.

data on early complications in Hungary during the period 1960–67.[75] Černoch, in 1965, reported similar figures for Czechoslovakia, without specifying the coverage: Injuries—0.6 per 1,000 abortions, inflammation—5 per 1,000 abortions, 'more profuse bleeding'—3 per 1,000 abortions.[85]

Information on the sequelae of legal abortion in eastern Europe is scanty. In Hungary, premature birth tends to occur more frequently among women who have had induced abortions than among women who have not had them. This is true regardless of age, parity, employment, and other characteristics of the mother.[86–87] The frequency of prematurity tends to increase with the number of prior induced abortions. However, while prematurity is associated with high infant mortality, legal abortions preceding childbearing have not been numerous enough in Hungary to prevent a drop in infant mortality from 58.8 per 1,000 live births in 1956 to 38.4 per 1,000 in 1966.

In summary, then, abortion laws and abortion practices in Europe run the gamut from the traditional restrictions which prevail mainly in the West and South, through liberalization in the North and in Britain, to complete or almost complete legalization in a number of countries of the East. Whatever direction our own way of dealing with abortion takes, we can draw on the experience of Europe and learn from it.

REFERENCES

1. Heiss, H., *Die Abortsituation in Europa und den aussereuropäischen Ländern*, Stuttgart, 1967.
2. Hubinont, P. O., 'Abortion in western and southern Europe: a preliminary study,' *Paper presented at the International Conference on Abortion, Hot Springs, Virginia, Nov. 17–20, 1968.*
3. Geiser, M., 'Zahlen und Gedanken zur legalen Schwangerschaftsunterbrechung in der Schweiz und im Ausland,' *Schweizerische Medizinische Wochenschrift, 86:* 1006–1010, 8 Sept. 1956.
4. Marr, S., 'Abortion à la Suisse,' *New Statesman*, 7 Apr. 1967.
5. Tietze, C., 'Legal abortion in Scandinavia,' *Quarterly Review of Surgery, Obstetrics and Gynecology, 16:* 227–230, Oct.-Dec. 1959.
6. Sweden: Laws, Statutes, etc., 'Interruption of pregnancy,' *International Digest of Health Legislation, 17:* 152, 1966.
7. Denmark: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 8:* 377–381, 1957.
8. Finland: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 2:* 559–561, 1951.
9. Norway: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 16:* 148–154, 1965.

10. FINKBINE, S., 'The lesser of two evils,' *The Case for Legalized Abortion Now* (A. F. Guttmacher, ed.), pp. 15–25. Berkeley, 1967.
11. RAPOPORT, J. L., 'American abortion applicants in Sweden,' *Archives of General Psychiatry, 13:* 24–33, July 1965.
12. Denmark: Justitsministeriet, *Betaenkning om Adgang til Svangerskabsafbrydelse*. Copenhagen, 1969.
12a. *Op. cit.*, p. 49.
12b. *Op. cit.*, p. 24.
12c. *Op. cit.*, pp. 182–188.
13. Sweden. Medicinalstyrelsen, *Allmän Hälso-och Sjukvård*. Stockholm, various years.
14. Denmark. Sundhedsstyrelsen, *Medicinalberetning for Kongeriget Danmark*. Copenhagen, various years.
15. Norway: Justisdepartementet, *Innstilling fra Straffelovrådet om Adgangen til å Avbryte Svangerskap*, p. 74. Trondheim, 1956.
16. Finland: Laakintohallitus, *Yleinen terveyden- ja sairaanhoito*. (Suomen Virallinen Tilasto, XI; 67), pp. 154–156. Helsinki, 1966.
17. ALDÉN, T., 'Om de illegala aborternas antal och geografiska fördelning,' *Abortfrågan* (Sweden: Inrikesdepartementet), pp. 222–234. Stockholm, 1953.
18. INGELMAN-SUNDBERG, A., 'Om de illegala aborternas antal och geografiska fördelning,' *Svenska Läkartidningen, 50:* 2386–2392, 13 Nov. 1953.
19. QUENSEL, C. E. and GENELL, S., 'Ha de illegala aborterna minskat under de senare åren?,' *Svenska Läkartidningen, 50:* 2784–2792, 24 Dec. 1953.
20. WAHLÉN, T., 'De illegala aborternas antal: en kommentar till abortbetänkandets bilaga II,' *Svenska Läkartidningen, 51:* 248–250, 29 Jan. 1954.
21. HOFFMEYER, H. and NØRGAARD, M., 'Konceptionshyppighed og svangerskabsforløb: undersøgelser og beregninger af den illegale aborthyppighed siden 1940,' *Ugeskrift for Laeger, 126:* 355–371, 12 Mar. 1964.
22. KLINTSKOG, E., 'Operationsriskerna vid legal abort,' *Abortfrågan* (Sweden: Inrikesdepartementet), pp. 252–261. Stockholm, 1953.
23. ORAM, V., 'Dødsårsag og dødelighed ved legal svangerskabsafbrydelse i årene 1940–50 i Danmark,' *Ugeskrift for Laeger, 114:* 482–485, 17 Apr. 1952.
24. BERTHELSEN, H. G. and ØSTERGAARD, E., 'Komplikationer og mortalitet ved legal abortus provocatus baseret på 23,666 anmeldelser til sundhedsstyrelsen i årene 1953 til 1957,' *Ugeskrift for Laeger, 120:* 1005–1009, 31 July 1958.
25. OLSEN, C. E., NIELSEN, H. B. and ØSTERGAARD, E., 'Abortus provocatus legalis: en analyse af 21,730 anmeldelser til sundhedsstyrelsen 1961–1965,' *Ugeskrift for Laeger, 129:* 1341–1351, 12 Oct. 1967.
26. OLKI, M., 'Die Abortsituation in Finnland,' *Internationale Abortsituation, Abortbekämpfung, Antikonzeption* (K-H Mehlan, ed.), pp. 64–69. Leipzig, 1961.
27. LINDAHL, J. M., *Somatic Complications following Legal Abortion*, Stockholm, 1959.
28. EKBLAD, M., 'Induced abortion on psychiatric grounds: a follow-up study of 479 women,' *Acta Psychiatrica et Neurologica Scandinavica*, suppl. *99:* 1–238, 1955.
29. JANSSON, B., 'Mental disorders after abortion,' *Acta Psychiatrica Scandinavica, 41:* 87–110, 1965.
30. ARÉN, P. and ÅMARK, C., 'The prognosis in cases in which legal abortion has been granted but not carried out,' *Acta Psychiatrica et Neurologica Scandinavica, 36:* 203–278, 1961.
31. HÖÖK, K., 'Refused abortion: a follow-up study of 249 women whose applications were refused by the National Board of Health in Sweden,' *Acta Psychiatrica Scandinavica, 39* (suppl. 168): 1–156, 1963.
32. FORSSMAN, H. and THUWE, I., 'One hundred and twenty children born after application for therapeutic abortion refused: their mental health, social adjustment and educational level up to the age of 21,' *Acta Psychiatrica Scandinavica, 42:* 71–88, 1966.
33. WILLIAMS, G., *The Sanctity of Life and the Criminal Law*, p. 152. New York, 1957.
34. FERRIS, P., *The Nameless: Abortion in Britain Today*, pp. 42–48. London, 1966.
35. DIGGORY, P. L. C., 'Some experiences of therapeutic abortion,' *Lancet, 1:* 873–875, 26 Apr. 1969.
36. Abortion Law Reform Association, *Alra Newsletter No. 19*. Late Summer 1967.
37. HINDELL, K. and SIMMS, M., 'How the abortion lobby worked,' *Political Quarterly, 39:* 269–282, July–Sept. 1968.

38. United Kingdom: Laws, Statutes, etc., 'Interruption of pregnancy,' *International Digest of Health Legislation, 19:* 887–889, 1968.
39. United Kingdom: Laws, Statutes, etc., *The Abortion Regulations 1968*, London, 1968.
40. British Medical Association: Committee on Therapeutic Abortion, 'Indications for termination of pregnancy,' *British Medical Journal, 1:* 171–175, 20 Jan. 1968.
41. Abortion Law Reform Association, *A Guide to the Abortion Act 1967*, London, 1968.
42. PEEL, J. and POTTS, M., 'Demographic aspects of abortion in Britain,' *Paper presented at the Conference of the International Union for the Scientific Study of Population*, London, 3–11 Sept. 1969.
43. SIM, M., 'Abortion and the psychiatrist,' *British Medical Journal, 2:* 145–148, 20 July 1963.
44. Abortion Law Reform Association, *Alra Newsletter*, No. 21, Summer 1968.
45. MEHLAN, K-H. (ed.), *Internationale Abortsituation, Abortbekämpfung, Antikonzeption*, Leipzig, 1961.
46. TIETZE, C. and LEHFELDT, H., 'Legal abortion in Eastern Europe,' *Journal of the American Medical Association, 175:* 1149–1154, 1 Apr. 1961.
47. TIETZE, C., 'The demographic significance of legal abortion in Eastern Europe,' *Demography, 1:* 119–125, 1964.
48. POTTS, M., 'Legal abortion in Eastern Europe,' *Eugenics Review, 59:* 232–250, Dec. 1967.
49. FIELD, M. G., 'The re-legalization of abortion in Soviet Russia,' *New England Journal of Medicine, 255:* 421–427, 30 Aug. 1956.
50. Bulgaria: Laws, Statutes, etc., 'Interruption of pregnancy,' *International Digest of Health Legislation, 8:* 605–607, 1957.
51. Czechoslovakia: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 10:* 283–292, 1959.
52. Hungary: Laws, Statutes, etc., 'Interruption of pregnancy', *ibid., 9:* 536–540, 1958.
53. Poland: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 9:* 319–323, 1958.
54. Yugoslavia: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 12:* 619–622, 1961.
55. Czechoslovakia: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 13:* 491–492, 1962.
56. VOJTA, M., 'A critical view of vacuum aspiration: a new method for the termination of pregnancy,' *Obstetrics and Gynecology, 30:* 28–34, July 1967.
57. KERSLAKE, D. and CASEY, D., 'Abortion induced by means of the uterine aspirator,' *ibid., 30:* 35–45, July 1967.
58. MEHLAN, K-H., 'Die Abortsituation in der Deutschen Demokratischen Republik,' *Internationale Abortsituation, Abortbekämpfung, Antikonzeption* (K-H. Mehlan, ed.), pp. 52–63. Leipzig, 1961.
59. German Democratic Republic: Laws, Statutes, etc., 'Protection of the mother and the child,' *International Digest of Health Legislation, 4:* 58–61, 1952.
60. MEHLAN, K-H., 'Die Abortsituation im Weltmaßstab,' *Arzt und Familienplanung*, pp. 69–99. Berlin, 1968.
61. MEHLAN, K-H. and FALKENTHAL, S., 'Der legale Abort in der Deutschen Demokratischen Republik: Statistik der Jahre 1953–1962,' *Das Deutsche Gesundheitswesen, 20:* 1163–1167, 24 June 1965.
62. Romania: Laws, Statutes, etc., 'Interruption of pregnancy,' *International Digest of Health Legislation, 18:* 822–837, 1967.
63. Bulgaria: Laws, Statutes, etc., 'Interruption of pregnancy,' *ibid., 19:* 589–602, 1968.
64. MEHLAN, K-H., 'Combating illegal abortion in the socialist countries of Europe,' *World Medical Journal, 13:* 84–87, May–June 1966.
65. VOJTA, M., 'Die Abortsituation in der Tschechoslowakischen Sozialistischen Republik,' *Internationale Abortsituation, Abortbekämpfung, Antikonzeption* (K-H. Mehlan, ed.), pp.107–113. Leipzig, 1961.
66. SRB, V. and KUČERA, M., 'Potratovost v Československu v letech 1958–1962,' *Demografie, 5:* 289–307, 1963.
67. Czechoslovakia: Ministerstvo Zdravotnictvi, 'Potraty,' *Zdravotnická Statistika ČSSR*. Prague, various years.
68. HIRSCHLER, I., 'Die Abortsituation in der Volksrepublik Ungarn,' *Internationale Abortsituation, Abortbekämpfung, Antikonzeption* (K-H. Mehlan, ed.), pp. 114–122. Leipzig, 1961.
69. Hungary: Központi Statisztikai Hivatal, *Magyarország népesedése: demográfiai évkönyv* (Statisztikai idöszaki közlemenyek). Budapest, various years.
69a. *Op. cit.* for 1965, p. 102.

70. Yugoslavia. Slovenia: Zavod za Zdravstveno Varstvo, *Zgodnja Fetalna Smrtnost v SR Sloveniji, 1955–1964*. Ljubljana, 1966.
71. Yugoslavia. Slovenia: Zavod za Zdravstveno Varstvo, *Splav in Njegovo Preprecevanje v SRS v Letu 1965*. Ljubljana, 1966.
72. ANDOLSEK, L., Personal communication.
73. Czechoslovakia: Ministerstvo Zdravotnictvi, *ČSSR zdravotnictvi 1968 (1967)*, p. 26. Prague, 1968.
74. GÁL, G., NÉMETH, A. and FAZEKAS, S., 'Ein Beitrag zur Frage der septischen, kriminellen, postabortalen Nierenkomplikation,' *Zeitschrift für Ärztliche Fortbildung, 59:* 592–596, 1 June 1965.
75. HIRSCHLER, I., *Material presented at the International Conference on Abortion, Hot Springs, Virginia, Nov. 17–20, 1968.*
76. MEHLAN, K-H., 'Legal abortions in Roumania,' *Journal of Sex Research, 1:* 31–38, Mar. 1965.
77. Romanian Communist Party: Central Committee, 'Analiza starii de senatate a populatiei si masurile privind perfectionarea organizarii retelei sanitare si imbunatatirea asistentei medicale in Republica Socialista Romania,' *Scinteia*, 27 Oct. 1968.
78. ČERNOCH, A., *Material presented at the International Conference on Abortion, Hot Springs, Virginia, Nov. 17–20, 1968.*
79. NOVAK, F., *ibid.*
80. Sweden: Inrikesdepartementet, *Abortfrågan. Betänkande avgivet av 1950 års abortutredning* (Statens Offentliga Utredningar 1953: 29), p. 221, Stockholm, 1953.
81. FRANDSEN, E., MOSBECH, J. and MØLGAARD, B., 'Abortus provocatus i Danmark i 1955 og 1957,' *Ugeskrift for Laeger, 121:* 1538–1543, 1 Oct. 1959.
82. PETTERSON, F., *Epidemiology of Early Pregnancy Wastage*, p. 89, Stockholm, 1968.
83. HUDCOVIČ, A., 'Technika interrupcie,' *Československá Gynekologie, 25:* 650–657, Nov. 1960.
84. SZENDI, B., LAKATOS, I. and TÓTH, Z., '23,300 Schwangerschaftsunterbrechungen im Spiegelbild der Operationsmethode und der Frühkomplikationen,' *Zeitschrift für Ärztliche Fortbildung, 54:* 751–756, 1 July 1960.
85. ČERNOCH, A., 'Experiences in Czechoslovakia with the effects and consequences of legalized artificial termination of pregnancy,' *Paper Presented at United Nations World Population Conference, Belgrade, 30 Aug. to 10 Sept. 1965.*
86. BARSY, G. and SÁRKÁNY, J., 'A müvi vetélések hatása a születési mozgalomra és a csecsemöhalandóságra,' *Demográfia, 4:* 427–467, 1963.
87. MILTÉNYI, K., 'A müvi vetélések hatásainak kérdésehez,' *Demográfia, 7:* 73–87, 1964.



EDITORIAL

LEGAL ABORTION WITHOUT HOSPITALIZATION

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EDMUND W. OVERSTREET, MD, FACOG

OBSTETRICIANS TODAY are fearfully watching the rising numbers of legal abortions now being performed in various areas of the United States. Rates in some major hospitals have reached 300–500 abortions per 1000 births and continue to increase. In California, since the liberalized (but still moderately restrictive) law took effect in Nov 1967, the rate for the entire state has doubled for each 6-month period. Now it has reached about 60 per 1000 births.

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Submitted for publication May 22, 1970.

The illustration at the top of the page is from a 15th-century German woodcut. (The Bettmann Archive).

Now that Hawaii, Alaska and New York have repealed all restrictive statutes, those states may be expected rapidly to reach and, doubtlessly, to surpass California's experience. The widespread movement throughout the United States to remove abortion from the ambit of the law and return it to the physician-patient relationship is building enormous impetus and impact. If and when this occurs, the sheer numbers of abortions may well become overwhelming. For example, despite the 15,000-odd legal abortions performed in California in 1969, it is estimated fairly reliably that approximately 76,000 illegal abortions were performed upon California women during that time. Should abortion-on-request simply for the unwanted pregnancy soon become legal, the prospect of 90,000-odd abortions per year would be awesome indeed. Physicians in states in which repeal has already been accomplished are already fearful that the influx of patients from surrounding states may well approximate such a situation. Hence, it is the hope of many that when repeal does come it will be mediated by a major national judicial or legislative decision which will apply to *all* states uniformly, rather than being brought about by spotty, gradual repeal state by state.

Already, however, many hospitals and their staffs are encountering increasing problems in handling the present numbers of abortions. Encroachment on available hospital beds, limited operating room time, overwhelmed admissions personnel, preoccupation of hospital staff time, and the revolt of residents are only a few of the troubles which have developed. Since we may expect these problems to be compounded tremendously as liberalization of abortion proceeds, it is essential for us to plan ahead in organizing our abortion procedures to handle the expected load.

Various solutions to these problems have been proposed. All of them are ameliorative to some degree. It seems likely that for a

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period of time, at least, the performance of legal abortions will be reserved to licensed physicians and restricted to hospital premises. Hence, any methodology which spares hospital bed space, operating room time and hospital personnel deserves our serious consideration and our immediate attention in planning for the future.

For these reasons, we wish to draw attention to the experience of this department in the use of outpatient, come-and-go, first-trimester abortion by uterine suction evacuation, and to emphasize the simplicity and the safety of this procedure. Although this method has been used very extensively in Eastern European countries and in Japan, American physicians have been distrustful of it and reluctant to adopt the procedure. Our own preliminary experience in 55 outpatients was presented by one of us (AJM) at the annual meeting of the American Association of Planned Parenthood Physicians in Boston on April 10, 1970, and details of the results will be published elsewhere.* Since these details will not appear, however, for almost a year, and because the matter is so urgently important, we feel that a brief summary of the results should be presented here.

Fifty-five patients with pregnancies of no greater that 12 weeks' menstrual duration had initial work-ups and therapeutic abortion adjudication procedures as outpatients. Each patient presented herself at our regular come-and-go surgery suite approximately one hour before the scheduled procedure, having been prohibited any oral intake since the previous midnight. Aspiration abortion was then performed, either under light general anesthesia or intravenous analgesia plus paracervical block. A standard aspiration apparatus was used together with the vibrodilator.† The patient was then observed in the postanesthesia recovery room until fully ambulatory and then returned home—always accompanied by some relative or friend.

Significant aspects of this procedure are as follows. Mean time spent on the hospital premises for the 55 patients was 3.4 hr (range, 1.1–5.4 hr). Fifty patients with similarly conducted inhospital abortions had a mean hospital stay of 37 hr (range, 11–54 hr). Mean *measured* blood loss at operation was 25 ± 6 ml (range, 20–125 ml) under paracervical block, whereas under light general anesthesia it was 66 ± 15 ml (range, 20–350 ml). Earlier studies had shown that Fluothane tends to double the blood loss at aspiration abortion, so this gas was never used. The operative procedure for patients under general anesthesia required approximately 30 min, whereas for those under paracervical block, it increased to about 50 min because of the time required for the analgesia and for the block to "take." Moreover, the time required for the patient with a paracervical block to recover fully from the somewhat heavier analgesia tended to prolong her stay in the recovery room.

Of greatest interest, of course, is a consideration of complications incidental to this methodology. There were none at operation, although, in 3 patients, difficulty in accomplishing cervical dilatation dictated abandonment of the outpatient procedure and admission to hospital for the abortion. It seems advisable not to undertake come-and-go aspiration abortion in patients with very firm, tight cervices.

Eight of the 55 patients were seen later in the emergency room for postabortal complications: postabortal bleeding (5), mild endometritis (2), and subacute salpingitis (1). Of these, 3 were admitted to hospital for 2-day stays. Of 50 patients with inpatient abortions, 7 had comparable postabortal complications and 2 were similarly readmitted to hospital. Of greatest significance is the fact that none of these post-

* Advances in Planned Parenthood (Vol 6). Edited by AJ Sobrero, C McKee. New York, Excerpta Medica Foundation, (in press)

† Berkeley Tonometer Co, Berkeley, Calif.

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abortal complications—all of which were handled with minimal therapy—developed earlier than 2 days after abortion, and most occurred from 3 to 30 days after the procedure. So, it is important to emphasize that the conventional 12- to 48-hour hospital admission for aspiration abortion patients serves no real purpose either in preventing or discovering postabortal complications. This fact alone speaks strongly for the feasibility and desirability of accomplishing early abortion as a come-and-go outpatient procedure—provided that the circumstances, auspices and skills brought to bear are of the highest quality.

In the light of our own experience, we feel that this methodology for legal abortion should be given extensive trial in the hope of minimizing the logistic problems created by our mounting abortion rates.

University of California Medical Center
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Item No. 54

ON THE HEALTHINESS OF FOUR THOUSAND ABORTIONS IN A FREE STANDING ABORTION SERVICE

Horace Hale Harvey, III, M.D.

Barbara Yarnell Elizabeth Pyle

We would first like to thank the people of New York, their legislators, and the Public Health Board for a law and a policy that allows for improvement and self-correction. This is a great moral step necessary to remove the fear of abortion.

We would next like to thank the National Clergy Consultation Service on Abortion (especially Reverend Howard Moody and Arlene Carmen) and the five hundred clergymen throughout the United States who with their pioneering spirit have led the way in the concept of abortion reform. Planned Parenthood is likewise to be commended for its stand on this issue.

Lastly, we would like to offer a heartfelt thanks to the doctors working with us, the nurse-counselors, and to the entire staff of the Community Sex Information and Education Service. Our efforts and dreams would have come to nothing without your hard work and loyalty.

INTRODUCTION

New York is to be commended for leading the country in the repeal of abortion laws. The new law provides that a physician can perform an abortion under conditions that are healthy and safe on a consenting woman up to the twenty-fourth week of pregnancy. This law will inevitably become the model after which the rest of the country will pattern its laws when the reform becomes nationwide. As the New York law will become the model, so will New York's applications of this law. It is to the betterment of these future ends that we do hereby present this report.

The Community Sex Information and Education Service (hereinafter called CSI) is a not-for-profit incorporation devoted to developing nationwide sex education. In July of this year, the National Office of CSI recognized the need for there to be a quality control on the means whereby women in New York receive abortions. This conclusion was reached based upon the many phone calls that poured into our office and into the office of the Clergy and Lay Advocates for Hospital Abortion Performance complaining of the abusive treatment and the exploitive prices by many of the doctors, the profiteering referral agencies, and the hospitals performing abortions in the metropolitan area.

With the tripartite goal of safety, price control, and psychological health, CSI formed Women's Medical Group to act as a consumer control for women seeking abortions in the first ten weeks of pregnancy. Women's Medical Group is able to monitor the safety of the procedure by setting standards for the equipment and the methods, by supervising the participating doctors and by having a comprehensive follow up program consisting of a Women's Medical Group "hot line" telephone number making available to the women 24 hours a day, a doctor or a Registered nurse to answer any questions relating to the procedure or to their condition following the procedure. With these means, and a medical questionnaire completed and returned by the patient ten days later, Women's Medical Group is able to evaluate the participating doctors, and thereby offer the patients a safe procedure.

Women's Medical Group has been able to control abortion pricing since July 1, for slightly over 4,000 abortions by referring only to doctors who have agreed to charge a reasonable fair price, and who have also agreed to perform 25% of the procedures at no charge at all to welfare and indigent patients. The third goal of CSI, psychological health, is perhaps the factor that makes Women's Medical Group so unusual. To achieve this goal, the Group furnishes counselors who work closely with the doctors performing the abortions. The majority of these counselors are registered nurses who have had abortions themselves, and are therefore naturally sensitive to the complicated feelings and reactions that an abortion evokes in a woman. In addition, these nurses have received special training to enable them to deal with the varied psychological aspects and impacts of abortion.

To the furtherment of these three goals, and to the further help of the women of New York, we offer these statistics on the healthiness of 4,000 abortions performed by a free standing abortion service.

For operational details of Women's Medical Group, please see the attached appendix.

Abortion safety is usually measured by comparing the rates of the following medical complications which are often associated with abortions: death, shock, bleeding, infection, perforation, and incomplete abortion.

A) In four thousand abortions performed since July 1 using a local anesthetic, there have been no deaths and no cases of shock or cardiac arrest. This perfect record should be contrasted with the death rates ranging from two to five per one hundred thousand cases, which have occurred in the European and New York hospitals due to the use of general anesthesia for early abortions. The only abortion death in London last year was due to general anesthesia.

B) The bleeding varied from only a few drops in four to six week pregnancies to an average of about one ounce for cases eight to ten weeks pregnant. One ounce is the amount of blood loss a woman ordinarily has during a normal period. However, in our four thousand cases we also had three women who unexpectedly turned out to be ten to twelve weeks pregnant and who lost about a pint of blood during the abortion. This does not represent a serious blood loss, since one pint of blood is the usual amount of blood given during a blood donation to a blood bank. We also had one patient who was sixteen weeks pregnant and who lost about two pints of blood. No woman required a blood transfusion or intravenous fluids. It is important to note that all four of these women were found unexpectedly to be over ten weeks pregnant, thus we have every reason to believe that no woman who is less than ten weeks pregnant will bleed on an average more than she does with a normal period, and the earlier the abortion the less the blood loss. Independent research (*Obstetrics and Gynecology*, September-1970) has shown that abortions done in hospitals with general anesthesia result in about twice the blood loss of abortions done with local anesthesia. This is probably because general anesthesia prevents uterine contraction which normally would prevent bleeding.

C) Fever and Infection - We had four patients of the one thousand five hundred and sixty who returned our research form, who reported they had fever of 100.4 degrees or more for one day or more. In two of these cases the fever returned to normal in two days, while in two other cases the fever returned to normal in three days. None of these patients with fever required hospitalization.

D) Perforated Uterus - This is the condition resulting when an abortion instrument goes through the uterine muscle wall. We have had nine such cases in four thousand abortions. However, eight of these cases occurred during the first two thousand abortions, whereas only one of these nine cases occurred during the second two thousand cases. This indicates that as the physicians gain experience and become more skilled, they are less likely to perforate a uterus. In fact, the one later perforation was by one of the newer and less experienced physicians (and in a ten and one half week pregnancy).

Thus, we have every reason to believe that uterine perforation can be eliminated as doctors gain skill at doing early abortions. Of the first eight perforations, only three were hospitalized. Two of these hospitalizations were found to be fifteen weeks pregnant. There was only one out of seven perforations in pregnancies less than ten weeks which required hospitalization. Therefore, perforations of such early pregnancies are not as serious a complication as it has been thought to be in the past, since none of these had later complications. All three of our hospitalizations were discharged without complications within three or four days.

E) Incomplete Abortion - We have had one such case wherein the physician suspected in advance that he had not completed the abortion, because he found no pregnancy tissue when he examined the tissue removed from the uterus. (We require that physicians examine all tissues removed from the uterus to make certain that they have removed the entire pregnancy.) In this case, since the patient was only four or five weeks pregnant, the physician could not be sure that he completed the abortion, since in such an early pregnancy there is little or no tissue to be found. Thus, we asked this patient to have another pregnancy test done by us two weeks later. This test proved positive, so the abortion was completed immediately without complications. Let us now compare the complication rates of these 4,000 abortions with those rates of complications in New York hospitals' early abortions. This data is summarized as follows:

Complication	N.Y. Hospitals % Less Than 12 Weeks	WMG Gross % All Cases	WMG Correct % Less Than 12 Weeks
Hemorrhage	.2	.1	.0
Infection	.2	.2	.2
Perforation	.2	.2	.1
Others	.4	.025	.025
	1.0%	.525%	.325%

The third column above is corrected in the sense that in it we have removed all abortion cases of 12 week or more pregnancies, since this was done in the above hospital data. Comparing the above complication rates suggest that Women's Medical Group has had about one-third to one-half the overall complication rate of the New York hospitals. Since the number of these complications is so small in both Women's Medical Group and New York hospitals, the most important fact is that the New York hospitals have had deaths whereas Women's Medical Group has had none. Generally, from this data it can be concluded that early abortions (or abortions less than 12 week pregnancies) are very safe and free from serious medical complications, whether or not they are done in a free standing abortion service such as Women's Medical Group or in a hospital, just as long as no general anesthetic is used. In fact, from the point of view of medical techniques and safety, an early abortion is similar to having a tooth pulled - both usually involve the use of a local anesthetic, both usually involve very little loss of blood, both can easily be done relatively quickly on an ambulatory basis (*e.g.*, during a lunch hour), both have similar "non-fatal" complications and dangers which occur in the range of one per each thousand cases. Thus, in view of the new evidence of the safety of abortion done in free standing abortion services, it would seem hard to justify more medical precautions for an abortion than we require for having a tooth pulled.

CURRENT INVESTIGATION

Aspiration abortion without cervical dilation

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Aspiration abortions on 67 conscious patients with pregnancies of 10 weeks' duration or less were performed successfully without cervical dilation and with minimal risk of perforation, with the use of a 6 mm. diameter flexible plastic cannula. Four other women required slight dilation of the cervix to complete the abortion. There was no significant morbidity in any patient. This simple technique should be useful in future large-scale abortion programs in licensed clinics.

WHILE ASPIRATION ABORTION is accepted widely as a safe and effective technique, any modification is important which will make the procedure more simple, more safe, and less time-consuming without sacrificing completeness of uterine evacuation. Also, if performed without anesthesia or only with paracervical block, an anesthesiologist need not be in attendance and the morbidity of general anesthesia is not incurred.

Although it has been customary to use a cannula whose outside diameter in millimeters is equal to the duration of pregnancy in weeks,[1] evacuation can often be effected without dilation.[2] Such a technique shortens the procedure, decreases discomfort in the conscious patient, and decreases risk of cervical injury.

Our study was conducted to test the efficacy of a flexible 6 mm. diameter plastic aspiration cannula* (Fig. 1) developed by Harvey Karman to remove early first-trimester products of conception. This flexible cannula has two openings at its tip which permit bending without blockage if it is applied to the uterine fundus.

From the San Francisco Center for Legal Abortion; Planned Parenthood–World Population, Alameda-San Francisco; and the Department of Obstetrics and Gynecology, University of California.

Procedure

Seventy-two pregnant women whose last menses had occurred 10 weeks or less earlier were selected only on the basis of their willingness to be aborted while awake.

Preliminary procedures† included a medical and psychosocial history, physical examination, routine laboratory studies, Rh-antibody screening, and cervical culture for gonorrhea. The abortions were performed on a come-and-go basis at this medical center in a small surgical room attached to an op-

*Supplied as Vacurette F-6mm by Berkeley Bio-Engineering Company, Berkeley, California.

†Approval of patients for abortion was in accord with the revised California statute.

erating suite. Many patients received an oral analgesic one hour before the procedure, while others had no premedication.

A medium Graves speculum was used to expose the cervix, which was then fixed with a tenaculum. A paracervical block was performed by injecting 4 ml. of one per cent lidocaine at each of 4 sites (3, 5, 7, 9 o'clock) 1 cm. deep to the vaginal fornix. The operator cleansed the cervix and vagina with povidone-iodine solution while waiting for the block to become effective. The uterus was sounded to verify its depth and confirm its inclination. The 6 mm. cannula was then passed to the fundus and, while negative pressure (60 to 70 cm. Hg) was applied, it was moved within the uterus to aspirate all parts of the cavity. The duration of aspiration was timed and the procedure was concluded when the uterine walls seemed closely applied to the cannula.

Completeness of evacuation was checked by exploring the uterine cavity with a small curette. When aspiration through the 6 mm. cannula did not produce sufficient tissue, the cervix was dilated to 8 or 9 mm. and a larger aspirator was used to ensure total tissue removal. All specimens were examined to confirm the presence of the products of conception, then sent to the pathology laboratory. Aspirated blood and amniotic fluid were also measured. The patient was discharged within an hour, with an appointment for a 2 week postabortion visit.

During the procedure, each patient was attended by a counselor who explained the procedure and gave encouragement and support.

Results

Of the 72 women (Table I), aspiration abortion was completely successful in 67; 4 required cervical dilation and a larger cannula to empty the uterus. In 1 primigravida the internal os could not be identified by probe or small dilator. The procedure was stopped, and 2 weeks later abortion was performed without difficulty under general anesthesia. Mean aspiration time for the 67 successful cases was 3 minutes (range 1 to 7 minutes), and blood loss averaged 58 ml. (range 10 to 170 ml.).



Fig. 1. The 6 mm. flexible cannula with connecting tubing showing the double opening and a band marking 10 to 12 cm. from the tip.

No patient presented any evidence of a morbid, febrile postabortal course. One patient was observed in the hospital after abortion because products of conception were not positively identified in the pathology laboratory and a diagnosis of ectopic pregnancy was considered but not confirmed. Another patient was seen 7 days postabortion in the emergency ward with the sudden onset of uterine bleeding. She was sent home with a diagnosis of nonsignificant bleeding from the organizing placental site. Five patients telephoned with minor questions which required reassurance only.

Seventy of the 72 women were seen at the 2 week postabortion checkup; the other 2 verified by telephone that they had no problems.

Comment

Abortions performed on healthy women, many of whom are young primigravidas, require meticulous scrutiny and safeguards to minimize early as well as late morbidity and death. There are several obvious advantages in performing early abortions without general anesthesia or cervical dilation. By avoiding general anesthesia, a small but definite risk is eliminated and the procedure is more economical of medical personnel and cost. With-